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	08/25/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure possibility of abuse was thoroughly investigated for 1 of 3 residents (R), R1 reviewed.R1 obtained multiple bruises of unknown origin; the facility did not complete a thorough investigation of the incident.Federal regulation states, 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: S483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.R1 was admitted on [DATE] with diagnoses that include dementia with anxiety and behaviors, atrial fibrillation, obesity, fibromyalgia, insomnia, and low back pain. R1's minimum data set (MDS), dated [DATE], notes R1 has severe cognitive impairment, is independent with bed mobility and ambulation using a wheeled walker. R1 requires supervision or touching assistance with transfers, toileting, and eating. Surveyor spoke with R1 who could not articulate well enough to communicate effectively.On 08/25/25, Surveyor reviewed the facility self-report that identified Certified Nursing Assistant (CNA) C gave R1 a shower on 08/17/25 and discovered multiple bruises:-3 bruises on right forearm: 3 x 3 cm, 0.7 x 0.6 cm, 0.5 x 0.5 cm.-2 bruises on eft upper arm: 6 x 4.5 cm, 1 x 0.4 cm-1 bruise on left calf: 6.3 x 4.2 cm-1 bruise of right calf: 5 x 4.5 cm-1 bruise behind left knee: 7.7 x 10 cm-1 bruise behind right knee: 14 x 9 cmThis was immediately reported to Registered Nurse (RN) D who assessed R1, updated Director of Nursing (DON) B, R1's activated Power of Attorney, and the on-call physician. RN D obtained statements from all staff working at that time and interviewed residents if they were hurt or feel safe. No concerns were identified; however, there were no skin checks completed to observe for bruising for non-interviewable residents to ensure this was not abuse.-Assessment identified: R1 is alert and oriented to person only, has impaired memory, unstable walking, and was not able to remember how bruising would have occurred. RN D noted that no staff saw how bruises would have occurred and R1 receives blood thinning medication. -Physician ordered CBC and INR labs to be drawn on 08/18/25.-Statement written by CNA C on 08/17/25 mentioned the cause could have been from rolling up compression stockings. There was no evidence that the facility investigated this as a possible cause. DON B began a misconduct investigation on 08/17/25 and noted the following: DON reviewed previous skin assessments from 08/03/25 of which were negative for any acute findings. R1 had an INR on 08/14/25 that was 4.2 with orders to hold the coumadin dose that evening and resume coumadin therapy on 08/15/25. It is noted that R1 sits on hard wooden chairs at meals; secondary to her elevated INR, DON is resolving this report claim.The facility assumed the cause of the bruising was the high INR and resident sitting hard on the wooden chair in the dining room. Surveyor observed the chair did have a cushion that would protect the back of residents' legs and back; however, nothing was noted how the bruising on the arms possibly occurred. A critical event form was completed by the interdisciplinary team (IDT) on 08/17/25 that indicated, The toilet is a hard seat, a shower chair potentially as well. There is no evidence that an assessment or interventions were completed to address if the toilet seat and/or shower chair was the root cause.Surveyor reviewed R1's progress note dated 08/15/25. Note stated R1 hit staff multiple times during toileting. The staff had to finish up R1's cares, apply new pad, and pull up pants. They then assisted R1 to bed to rest. This was not investigated as potential root cause of the arm bruising. On 08/25/25, Surveyor asked RN E why this was not completed. RN E reported calling DON B who said once they found a high INR, they felt they did not need to look any further.

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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** Based on observations, interview and record review, the facility did not ensure the resident environment remains free from accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents for 1 of 3 residents (R) reviewed. (R1)R1 had multiple bruises to arms and legs. The facility did not find root cause of the arm bruises or put interventions in place to prevent reoccurrence and did not educate staff on ways to prevent injury or recurring bruises.Federal regulation states facilities must ensure that resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.R1 was admitted on [DATE] with diagnoses that include dementia with anxiety and behaviors, atrial fibrillation, obesity, fibromyalgia, insomnia, and low back pain. R1's minimum data set (MDS), dated [DATE], notes R1 has severe cognitive impairment, is independent with bed mobility and ambulation using a wheeled walker. R1 requires supervision or touching assistance with transfers, toileting, and eating. Surveyor spoke with R1 who could not articulate well enough to communicate effectively.On 08/25/25, Surveyor reviewed the facility self-report that identified Certified Nursing Assistant (CNA) C gave R1 a shower on 08/17/25 and discovered multiple bruises:-3 bruises on right forearm: 3 x 3 cm, 0.7 x 0.6 cm, 0.5 x 0.5 cm.-2 bruises on eft upper arm: 6 x 4.5 cm, 1 x 0.4 cm-1 bruise on left calf: 6.3 x 4.2 cm-1 bruise of right calf: 5 x 4.5 cm-1 bruise behind left knee: 7.7 x 10 cm-1 bruise behind right knee: 14 x 9 cmThis was immediately reported to Registered Nurse (RN) D who assessed R1, updated Director of Nursing (DON) B, R1's activated Power of Attorney, and the on-call physician. RN D obtained statements from all staff working at that time and interviewed residents on if they were hurt or feel safe. -Assessment identified: R1 is alert and oriented to person only, has impaired memory, unstable walking, and was not able to remember how bruising would have occurred. RN D noted that no staff saw how bruises would have occurred and R1 receives blood thinning medication.-Statement written by CNA C on 08/17/25 mentioned the cause could have been from rolling up compression stockings. There was no evidence that the facility addressed this issue to prevent possible recurrence of bruising.Surveyor reviewed the facility self-report, critical event form, and R1's electronic health record and found no documentation how the bruising on the arms possibly occurred and no intervention was added to the care plan to prevent recurrence of arm bruising. A critical event form was completed by the interdisciplinary team (IDT) on 08/17/25 that indicated, The toilet is a hard seat, a shower chair potentially as well. There is no evidence that an assessment or interventions were completed to address the toilet seat and shower chair to prevent recurrence of bruising.Critical event form also noted education was completed on 08/18/25; however, no education regarding interventions to prevent bruising was found following the incident on 08/17/25. Surveyor asked Registered Nurse (RN) E who verbalized calling DON B and reported back that they have no proof the education was completed after the incident. Surveyor reviewed R1's progress note dated 08/15/25. Note stated R1 hit staff multiple times during toileting. The staff had to finish up her cares, apply new pad, and pull up pants. They then assisted R1 to bed to rest. This was not investigated as potential reason for bruising and no new intervention was added to the care plan regarding how to mitigate combativeness during care for R1 to prevent further injury and bruising.On 08/25/25, Surveyor asked RN E why there was no interventions in place to protect R1's skin from recurrent bruising from the toilet, shower chair, or compression stockings that were identified as possible causes, and no interventions were added to address arm bruises. RN E requested to get back to Surveyor. RN E returned stating she called DON B and felt addressing the INR and the dining room chair was sufficient but understands they need to prevent recurring injury and bruising for R1.