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
	0015013	A. BUILDING: _____ B. WING _____	R-C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING EAGLES RIDGE	224 22ND AVENUE 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 a verification visit at Birch Haven Senior Living Eagles Ridge. Data was collected through 06/13/2024. One deficiency was identified. This deficiency was a repeat deficiency. See Statement of Deficiency 4U0L12, dated 08/17/2023. Census: 6 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{N 000}		
{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.	{N 427}		

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
	0015013	A. BUILDING: _____ B. WING _____	R-C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING EAGLES RIDGE	224 22ND AVENUE 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 427}	Continued From page 1	{N 427}		

This is a repeat deficiency. See Statement of Deficiency 4U0L12, dated 08/17/2023.

Findings include:

The provider is licensed to care for up to 8 residents in the client groups of: traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, emotionally disturbed/mental illness, and physically disabled.

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 indicated there would be independent activities, except for 06/22/2024, when the beauty shop would be open.

On 06/11/2024 at approximately 11:30 a.m., Surveyor interviewed Resident 1. Resident 1 told Surveyor there was not an activity every day. S/he said there was an activity about once a week.

On 06/11/2024 at approximately 11:35 a.m., Surveyor interviewed Resident 2 and asked about activities. Resident 2 told Surveyor, "We do a few things." Resident 2 told Surveyor there was not an activity planned daily.

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 that AD B worked on Mondays, Wednesdays, and Fridays. AT A said they have independent activities when AD B is not present. Surveyor asked clarification that there was no activity planned when AD B was not working. AT A told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015013	A. BUILDING: _____ B. WING _____	R-C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING EAGLES RIDGE	224 22ND AVENUE 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 427}	Continued From page 2 Surveyor, "Correct." The provider did not ensure an activity was planned daily for the residents.	{N 427}		