STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 05/11/2026 to 05/21/2026 Surveyor conducted a standard survey and complaint investigation at Bay Harbor of Deforest, a CBRF in Deforest. Fourteen deficiencies were identified. Six deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022, SOD T56511, dated 04/02/2024, SOD YSHR11, dated 06/06/2024, SOD YSHR12, dated 10/15/2024, SOD YSHR13, dated 01/13/2025 and SOD YSHR14, dated 05/27/2025. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 31	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, interview and record review, the provider did not ensure the provider complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) YSHR11, dated 06/06/2024 and SOD YSHR12, dated 10/15/2024. Findings include:	N 196		

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

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N 196	Continued From page 1 The provider was issued a regular license on 10/01/2022 to serve up to 40 residents with diagnoses including irreversible dementia/Alzheimer's, advanced age, physically disabled and terminally ill. Current Non-Compliance: From 05/11/2026 to 05/21/2026, Surveyor conducted a standard survey and complaint investigation. The complaint was substantiated and fifteen deficiencies were identified, including the following: Environment: - A menu was not posted and made available to residents. - Laundry was not handled in a way to prevent infection. - Two of four dryer vents were not made of rigid material. - Combustible material was stored within 3 feet of a furnace. - A fire drill was not conducted in the first quarter of 2026 and a fire drill simulating usual sleeping hours was not conducted in 2025. Employees: - One of 3 caregivers reviewed had an incomplete background check on file. - One of 3 caregivers reviewed did not have documentation of all trainings completed on file. - One of 1 caregivers reviewed, that had resided out of state in the past 3 years, did not have a background check completed with the state s/he had resided in. Resident Care/Records: - Two of 3 residents reviewed did not receive medication as prescribed.	N 196		

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N 196	Continued From page 2 - One of 3 residents reviewed did not have his/her individual service plan (ISP) followed. - Two of 3 residents reviewed did not have their ISPs updated with changes. - Two of 4 caregivers observed were not observed completing hand hygiene while assisting residents with eating and completing laundry tasks. - The provider did not have "Do Not Resuscitate" paperwork in a resident's record and accessible to emergency medical personnel when summoned for assistance. On 05/11/2026 at approximately 2:45 p.m., Surveyor reviewed identified concerns with Chief Operating Officer A, Administrator B and RN C. Chief Operating Officer A stated the survey did not go well. Survey History: SOD YSHR15, dated 10/09/2025: A verification visit with 0 deficiencies. SOD YSHR14, dated 05/27/2025: A verification visit, resulting in 2 deficiencies. One of 1 deficiencies were repeat deficiencies. SOD YSHR13, dated 01/13/2025: A verification visit, resulting in 4 deficiencies. Four of 4 deficiencies were repeat deficiencies. SOD YSHR12, dated 10/15/2024: A verification visit and 3 complaint investigations, resulting in 25 deficiencies. Sixteen of 25 deficiencies were repeat deficiencies. Three of 3 complaints were substantiated. The SOD resulted in special orders from the department including the following: - Order not to admit new or additional residents - extended.	N 196		

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N 196	Continued From page 3 - Order to develop and implement corrective measures in consultation with a registered nurse not currently affiliated with the facility and provide training regarding measures. - Provide legal representatives and copies of the SOD. SOD YSHR11, dated 06/06/2024: Three complaint investigations, resulting in 9 deficiencies. One of 9 deficiencies were repeat deficiencies. Three of 3 complaints were substantiated. The SOD resulted in special orders from the department including the following: - Order not to admit new or additional residents - Order to develop and implement corrective measures and provide training regarding measures. - Provide legal representatives and case managers copies of the SOD. SOD T56511, dated 04/02/2024: A standard survey and 3 complaint investigations, resulting in 12 deficiencies. Three of 12 deficiencies were repeat deficiencies. Two of 3 complaints were substantiated. The SOD resulted in special orders from the department to provide training to all staff on the corrective actions to resolve each deficiency. SOD 2U5R13, dated 10/30/2023: A verification visit, resulting in 0 deficiencies. SOD 2U5R12, dated 06/01/2023: A verification visit and complaint investigation, resulting in 6 deficiencies. One of 6 deficiencies was a repeat deficiency. The complaint was substantiated. SOD 2U5R13, dated 10/30/2023: A verification visit was completed, resulting in 0 deficiencies.	N 196		

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N 196	Continued From page 4 SOD 2U5R12, dated 06/01/2023: A verification visit and complaint investigation, resulting in 6 deficiencies. One of 6 deficiencies was a repeat deficiency. The complaint was substantiated. SOD 2U5R11, dated 02/01/2023: Two complaint investigations, resulting in 3 deficiencies. Two of 2 complaints were substantiated. The SOD resulted in special orders from the department to develop and implement corrective measures to resolve each deficiency and provide training. SOD PXZ011, dated 10/27/2022: A complaint investigation, resulting in two deficiencies. The complaint was substantiated. SOD 2R8O11, dated 09/19/2022: Two complaint investigations, resulting in 0 deficiencies. The complaints were not substantiated. SOD GRGR12, dated 08/15/2022: A verification visit, resulting in 0 deficiencies. SOD GRGR11, dated 06/02/2022: A standard survey, resulting in 5 deficiencies. SOD GNOK12, dated 07/20/2022: A verification visit and complaint investigation, resulting in 1 deficiency. The complaint was substantiated. SOD GNOK11, dated 02/17/2022: A complaint investigation was completed, resulting in 1 deficiency. The complaint was substantiated. SOD ASFH11, dated 01/06/2022: A complaint investigation was completed, resulting in 0 deficiencies. The complaint was unsubstantiated. Cross Reference: N0219 DHS 83.17(1) Licensee Conduct	N 196		

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N 196	Continued From page 5 Caregiver Background Check N0223 DHS 83.18(1) Employee Records Maintained And Current N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medications N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually And Upon Changes N0441 DHS 83.39(3) Handwashing N0450 DHS 83.41(2)(c) Nutrition: Menus N0454 DHS 83.42(1) Resident Records Maintained N0486 DHS 83.44(1)(a) Adequate Laundry Appliances Available N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0507 DHS 83.46(1)(f) Combustibles N0525 DHS 83.47(2)(d) Fire Drills Z0012 DHS 50.065(2)(bm) Out Of State Background Check	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.	N 219		

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N 219	Continued From page 6	N 219		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a background check was completed for 1 of 3 caregivers reviewed.

Caregiver F did not complete a background information disclosure.

Findings include:

According to The Wisconsin Caregiver Program Manual (P-00038), a complete Caregiver Background Check, at minimum, consists of:

1) A completed DHS form F-82064, Background Information Disclosure (BID).
2) A response from the Department of Justice (DOJ).
3) A Governmental Findings Report from DHS that reports the person's status, including administrative finding or licensing restrictions (GFR).

On 05/11/2026 at approximately 12:15 p.m., Surveyor reviewed employee files provided by Chief Operating Officer A. Records documented that Caregiver F was hired on 10/02/2025. The BID in Caregiver F's file was entirely blank.

On 05/11/2026 at approximately 12:30 p.m., Surveyor interviewed Chief Operating Officer A and asked if Caregiver F had a completed BID on file. Chief Operating Officer A reviewed Caregiver F's record and was unable to locate a completed BID. Chief Operating Officer A stated Caregiver F's BID would have been the responsibility of the facility's previous assistant administrator.

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N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation of all trainings were maintained in 1 of 3 employee records reviewed. The provider did not have record of Caregiver F receiving fire safety. Findings include: On 05/11/2026 at approximately 12:15 p.m., Surveyor reviewed employee files provided by Chief Operating Officer A. Caregiver F's record documented s/he was hired on 10/02/2025. Caregiver F's record did not include documentation of fire safety training. Surveyor checked the CBRF training registry, which did not indicate Caregiver F had received training for fire safety. On 05/11/2026 at approximately 12:50 p.m., Surveyor interviewed Caregiver F. Caregiver F stated s/he had taken fire safety with a University	N 223		

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	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

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N 223	Continued From page 8 of Wisconsin Green Bay (UWBG) instructor since his/her hire with the facility. Caregiver F was able to recall some details of the class. On 05/11/2026 at approximately 1:00 p.m., Surveyor requested documentation of Caregiver F's fire safety training or documentation of an exemption from Chief Operating Officer A. Chief Operating Officer A stated s/he knew Caregiver F completed the training in December 2025 but would have to reach out to UWGB to obtain documentation. On 05/11/2026 at 4:23 p.m., Chief Operating Officer A updated Surveyor that s/he was not successful in obtaining documentation of Caregiver F completing fire safety training.	N 223		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed received all medications as prescribed. Resident 1 did not receive his/her Novolog as prescribed 3 times from 04/01/2026 to 05/11/2026. Resident 2 did not receive his/her AM dose of Sennosides-Docusate Sodium 8.650 mg as	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 9	N 352		

prescribed 4 times from 04/29/2026 to 05/11/2026.

This is a repeat deficiency. See Statement of Deficiency (SOD) T56511, dated 04/02/2024, SOD YSHR12, dated 10/15/2024 and SOD YSHR14, dated 05/27/2025.

Findings include:

On 05/11/2026 at approximately 10:00 a.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 1:

Resident 1 was admitted to the provider's facility on 08/11/2025 with diagnosis of diabetes. Resident 1's physician orders included the following:

- Novolog 100 unit/ml (Start Date: 08/26/2025) - Inject at bedtime per the following sliding scale: 200-250=1unit, 251-300=2 units, 301-350=3 units, 351-400=4 units, >401=Call Provider
- Novolog 100 unit/ml (Start Date: 09/23/2025) - Inject 3 times daily prior to meals per the following sliding scale: 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, 401-450=Call provider.

Resident 1's medication administration record (MAR), dated 04/01/2026 to 05/11/2026, identified the following occurrences when Resident 1 did not receive his/her Novolog as prescribed:

- 04/01/2026 11:21 a.m. Blood Sugar(BS)=250 - 3 units administered.
*Per order, 2 units of insulin should have been administered.

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N 352	Continued From page 10 - 04/22/2026 11:55 a.m. BS=243 - 3 units administered. *Per order, 2 units of insulin should have been administered. - 05/06/2026 7:42 p.m. BS=343 - 4 units administered. *Per order, 3 units of insulin should have been administered. Surveyor was unable to clarify amount of insulin administered on 05/01/2026 at 4:53 p.m. when BS=304 as there was not documentation indicating number of units administered. On 05/11/2026 at approximately 2:45 p.m., Surveyor reviewed insulin administration errors with Chief Operating Officer A, Administrator B and RN C. Chief Operating Officer A reviewed the errors and stated, "How can you not read numbers," in reference to the caregivers. Example 2 - Resident 2: Resident 2 was admitted to the provider's facility on 02/05/2024. Resident 2's physician orders included an order, dated 04/29/2026, for Sennosides-Docusate Sodium 8.650 mg - Take 1 tablet 2 times daily; hold for loose stools. The order included a notation "Facility can send back every other day cycle card that would have started 5/1 in exchange for new twice daily cards." Resident 2's MAR, dated 05/01/2026 to 05/11/2026, documented Resident 2's AM dose was not administered on 05/04/2026, 05/06/2026, 05/08/2026 and 05/10/2026. Three of the dates documented "No Pass Reason: Other Problems" with no clarification. There was a notation on 05/10/2026 that stated "No Pass Reason: Not scheduled for today."	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

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N 352	Continued From page 11 On 05/11/2026 at approximately 2:45 p.m., Surveyor reviewed concern that Resident 2 had not been receiving his/her Sennosides-Docusate Sodium 8.650 mg 2 times daily as ordered on 04/29/2026. RN C checked the provider's medication cart and confirmed the Sennosides-Docusate Sodium 8.650 mg card in Resident 2's supply was only filled every other day. RN C concluded Resident 2's Sennosides-Docusate Sodium 8.650 mg card that was filled every other day was never swapped out with a card filled every day. Chief Operating Officer A stated a lead staff member was responsible for cycle fill tasks and s/he was unsure why this error occurred.	N 352		
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 the individual service plan (ISP) of 1 of 3 residents reviewed was followed. Resident 3 was transferred without the use of a hoyer lift as indicated in his/her ISP. This is a repeat deficiency. See Statement of Deficiency (SOD) GNOK11, dated 02/17/2022, SOD T56511, dated 04/02/2024 and SOD YSHR12, dated 10/15/2024. Findings include: On 05/11/2026 at 8:41 a.m., Surveyor observed Caregiver D and Caregiver E assist Resident 3	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 388	Continued From page 12 with a transfer from a chair in the common area to Resident 3's wheelchair. Surveyor observed Caregiver D and Caregiver E assist Resident 3 by pulling up under Resident 3's armpits and pulling the back of Resident 3's pants. Surveyor then observed Caregiver F move Resident 3's wheelchair over for Resident 3 to sit down with Caregiver F attempting to steady the wheelchair in place without brakes on. On 05/11/2026 at approximately 10:00 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 11/24/2021 with diagnoses including Alzheimer's disease and anxiety. Resident 3's ISP, dated 12/30/2025, documented that s/he required 1-2 staff to transfer and to use a gait belt. On 05/11/2026 at approximately 2:45 p.m., Surveyor shared observation of Caregiver D and Caregiver E assisting Resident 3 with a transfer without using a gait belt with Chief Operating Officer A, Administrator B and RN C. Chief Operating Officer A reviewed Resident 3's record and provided Surveyor with the current ISP, no date, that stated Resident 3 required a hoyer lift for transferring to wheelchair and to bed with 2 assist. RN C confirmed Resident 3 required a hoyer lift and should not have been transferred in the way s/he was by Caregiver D and Caregiver E.	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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 389	Continued From page 13	N 389		

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 ensure 1 of 3 resident individual service plans (ISP) were updated when there was a change in needs.

Resident 3's ISP was not updated to include fall preventions.

This is a repeat deficiency. See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022, SOD YSHR11, dated 06/06/2024, SOD YSHR12, dated 10/15/2024 and SOD YSHR13, dated 01/13/2025.

Findings include:

On 05/11/2026 at approximately 10:00 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 11/24/2021 with diagnoses including Alzheimer's disease and anxiety. Resident 3's record, dated 02/01/2026 to 05/11/2026, included documentation of the following falls with assessments that included the following interventions:
- 02/22/2026 6:17 p.m. Unwitnessed fall in dining room. Intervention: Team to continue assisting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 389	Continued From page 14 with all transfers and assist with toileting before meals. - 04/24/2026 12:50 p.m. Unwitnessed fall. Slipped off toilet. Intervention: Continue to assist with all transfers and assist with toileting before meals. Resident 3's ISP, not dated, documented the following: - Toileting: "Give total assistance to resident in managing bowel and bladder care. Assist with dressing and undressing, wash/wiping and with all required physical assistance daily at 7:00 a.m., 9:00 a.m., 11:00 p.m. 1:00 p.m." - Falls: "02/06/2025 - See fall risk eval (scheduled toileting added), Resident has started working with [physical therapy]. Resident has an increased risk for falls due to not being orientated to their own ability. Resident is at a medium risk for falls due to [his/her] deficient of not knowing their own ability such as when using an assisted device and getting up without assistance." On 05/11/2026 at approximately 2:45 p.m., Surveyor shared observation that Resident 3's fall prevention was not in his/her current ISP with Chief Operating Officer A, Administrator B and RN C. Chief Operating Officer A reviewed Resident 3's ISP and confirmed Surveyor's observation noting the most recent update to falls was 2025.	N 389		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 441	Continued From page 15 did not ensure each employee followed hand washing procedures according to Centers for Disease Control and Prevention (CDC) standards. Caregivers did not perform hand washing between tasks with different residents and after handling soiled laundry. Findings include: On 05/11/2026 at 8:35 a.m., Surveyor observed Caregiver E assist Resident 1 and Resident 2 with breakfast. Surveyor observed Caregiver E, using both hands, alternate between touching Resident 1's utensils and breakfast sandwich and Resident 2's utensils. Surveyor would also observe Resident 2 touching his/her utensils and food at times, attempting to feed him/herself. Surveyor did not observe Caregiver E perform hand hygiene between tasks with Resident 1 and Resident 2. On 05/11/2026 at 8:48 a.m., Surveyor observed Caregiver D assist Resident 3 and Resident 6 with breakfast. Surveyor observed Caregiver D, using both hands, alternate between touching Resident 3's utensils, breakfast sandwich and drink and Resident 6's breakfast sandwich and utensils. Surveyor did not observe Caregiver D perform hand hygiene between tasks with Resident 3 and Resident 6. On 05/11/1026 at 10:23 a.m., Surveyor observed Caregiver E complete laundry tasks. As Surveyor observed Caregiver E place soiled laundry into the wash machine with bare hands, Caregiver E stated, "I should have grabbed gloves." Surveyor then observed Caregiver E complete the laundry task and exit the laundry room without completing	N 441		

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	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 441	Continued From page 16 hand hygiene. "Hand hygiene protects both healthcare personnel and patients...Some healthcare personnel may need to clean their hands as often as 100 times during a work shift to keep themselves, patients and staff safe ...CDC provides the following recommendations for hand hygiene in healthcare settings ...Know when to clean your hands ...Immediately before touching a patient ...After touching a patient or patient's surroundings ...Immediately after glove removal ..." (Source: CDC Website, Clinical Safety: Hand Hygiene for Healthcare Workers, February 27, 2024, https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html (retrieval date - May 20, 2026).) On 05/11/2026 at approximately 2:45 p.m., Surveyor reviewed hand hygiene concerns with Chief Operating Officer A, Administrator B and RN C. Chief Operating Officer A replied, "Are you going to make me puke" as Surveyor began to discuss topic and made note of Surveyor's concern.	N 441		
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:	N 450		

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	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 450	Continued From page 17 Based on observation and interview, the provider did not ensure a weekly written menu was available to residents. This is a repeat deficiency. See Statement of Deficiency (SOD) YSHR12, dated 10/15/2024 and SOD YSHR13, dated 01/13/2025. Findings include: On 05/11/2026 at approximately 7:55 a.m., Surveyor entered the provider's dining area and observed several residents sitting at tables waiting for breakfast. Surveyor observed a whiteboard with the menu for 05/07/2026 listed. Surveyor was unable to locate a posting of a weekly menu or a listing of what would be served on 05/11/2026. On 05/11/2026 at 8:05 a.m., Surveyor asked a table of 4 residents what would be served for breakfast. Resident 7 stated the residents didn't know. On 05/11/2026 at 8:11 p.m., Surveyor asked Caregiver F, who was passing medications in the dining room, what would be served for breakfast. Caregiver F stated s/he was unsure. On 05/11/2026 at 8:22 a.m., Surveyor observed residents served an egg sandwich with fruit and a hashbrown. During the next approximately 15 minutes, Surveyor observed 3 residents request alternate food. On 05/11/2026 at 9:35 a.m., Surveyor interviewed Cook H. Cook H stated s/he had just started his/her second week with the provider. Cook H showed Surveyor a weekly menu that was on the	N 450		

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	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 450	Continued From page 18 counter in the provider's kitchen, which is not open to residents. Cook H stated s/he hadn't had an opportunity to update the whiteboard with today's menu yet, but that caregivers could always check the menu located in the kitchen to know what would be served each day. Cook H stated s/he was still learning resident preferences and was working on improvements with the dining process.	N 450		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 454	Continued From page 19 resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure records were maintained	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 454	Continued From page 20	N 454		

for 1 of 3 residents reviewed.

The provider did not maintain paperwork necessary to fulfill Resident 4's "Do Not Resuscitate" code status.

Findings include:

On 05/11/2026 at approximately 7:00 a.m., Surveyor reviewed a police report, obtained by Surveyor. The report documented that law enforcement was dispatched to the facility on 03/29/2026 at approximately 6:59 a.m. for a report of a pulseless nonbreathing individual, who appeared to be deceased and had a "Do Not Resuscitate" in order. The report stated while present at the facility, staff could not locate the proper documentation for a "Do Not Resuscitate" in the State of Wisconsin.

On 05/11/2026 at approximately 10:00 a.m., Surveyor reviewed Resident 4's record. Resident 4 admitted to the provider's facility on 12/01/2025 with diagnoses including Alzheimer's disease and congestive heart failure. Resident 4's facility face sheet and individual service plan (ISP), dated 01/13/2026, documented his/her code status as "Do Not Resuscitate." A progress note, dated 03/29/2026, stated a caregiver observed Resident 4 cold to the touch, pale, not breathing and without a pulse around 6:10 a.m. The progress note documented law enforcement arrived to the facility at approximately 7:04 a.m., followed by the coroner and funeral services.

Per "Emergency Care Do Not Resuscitate Order" only the Do Not Resuscitate bracelet identifies to Emergency Medical Service Responders that an individual is "Do Not Resuscitate. (DHS Division of Public Health - F44763, Emergency Care Do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 454	Continued From page 21 Not Resuscitate Order (DNR), 11/2022). On 05/11/2026 at approximately 2:45 p.m., Surveyor interviewed Chief Operating Officer A, Administrator B and RN C and asked if Resident 4's record included necessary documentation for his/her "Do Not Resuscitate" code status. Chief Operating Officer A reviewed Resident 4's closed record and was unable to locate "Do Not Resuscitate" paperwork.	N 454		
N 486	83.44(1)(a) Adequate laundry appliances available Laundry area. The CBRF shall make an adequate number of laundry appliances available to residents who choose to do their own laundry. The CBRF shall have a laundry area to sort, process and store clean and soiled laundry and shall handle clean and soiled laundry so as to prevent the spread of infection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure clean and soiled laundry was handled in a way as to prevent the spread of infection. Soiled laundry was observed overflowing in laundry baskets and on the floor in resident rooms. Findings include: On 05/11/2026 at approximately 11:20 a.m., Surveyor toured the provider's facility and observed the following laundry concerns: - A plastic garbage bag full of soiled laundry in	N 486		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

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N 486	Continued From page 22 Resident 1's shower. - A completely full laundry basket, which smelt of urine, in Resident 8's bedroom. - An overflowing laundry basket in Resident 2's room. - Soiled laundry on the floor in Resident 9's room. Laundry was also observed piled up on a dresser in Resident 9's room. Surveyor was unable to determine if clothing on the dresser was clean or soiled. - Laundry was piled on a desk at the "B Wing" nurses' station. - Resident 10 had a laundry basket that was overflowing with linens piled approximately 2 feet beyond the basket and resting against the wall. Resident 10 also had bedding piled in the corner of his/her room. Resident 10 reported s/he had just moved in 05/08/2026 and wasn't sure if the bedding on the floor was clean or soiled. - Resident 11 and Resident 12 had soiled laundry on the floor in their bathroom and a soiled chuck pad on the floor. Resident 11 reported that s/he went through a lot of pants due to his/her incontinence problem. Resident 11 stated the facility didn't do laundry on weekends and they hadn't received a laundry basket yet. Records indicated Resident 11 moved in on 05/08/2026 and Resident 12 moved in on 05/04/2026. On 05/11/2026 at approximately 2:45 p.m., Surveyor reviewed laundry concerns with Chief Operating Officer A, Administrator B and RN C. RN C acknowledged Surveyor's concern and stated s/he had just met with overnight staff to discuss laundry services.	N 486		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any	N 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 488	Continued From page 23 clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 4 dryers had vent tubing made of rigid material. Two of 4 dryers had semi-rigid venting. Findings include: On 05/11/2026 at approximately 11:20 a.m., Surveyor toured the provider's laundry rooms and observed 2 of 4 dryers had semi-rigid venting. "Flexible vents can twist, allowing lint to build up and catch on fire if it comes in contact with a sufficient amount of heat. If a fire starts beneath the dryer when the motor overheats, then the drafts from the dryer can pull the fire up into the duct, allowing a house fire to develop." ("Clothes Dryer Fires in Residential Buildings (2008-2010)", Topical Fire Report Series, Volume 13, Issue 7, August 2012, Page 7). On 05/11/2026 at approximately 2:45 p.m., Surveyor interviewed Chief Operating Officer A, Administrator B and RN C that 2 of 4 dryer vents were semi-rigid. Chief Operating Officer A stated s/he was unsure how those were missed in the past.	N 488		
N 507	83.46(1)(f) Combustibles.	N 507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 507	Continued From page 24 Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure combustible material was not placed within 3 feet of any furnace. The provider's furnace located near "A Wing" had pillows and cardboard stored within 3 feet of the furnace. Findings include: On 05/11/2026 at approximately 3:00 p.m., Surveyor observed the furnace room near "A Wing" with RN C. Surveyor observed cardboard and a box full of pillows stored next to the furnace. As Surveyor observed the items stored next the furnace, RN C confirmed the box appeared to be full of pillows and should be moved.	N 507		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 525	Continued From page 25	N 525		

hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure fire drills were conducted quarterly and that 1 drill was completed annually that simulated conditions during normal sleep hours.

The provider did not complete a fire drill during the first quarter of 2026 and did not complete a fire drill that simulated conditions during normal sleep hours in 2025.

Findings include:

On 05/11/2026 at approximately 11:20 a.m., Surveyor reviewed environmental records provided by Administrator B. Documentation indicated the following:

- Fire Drill completed on 03/27/2025 at 4:58 p.m.
- Fire Drill completed on 06/12/2025 at 9:00 a.m.
- Fire Drill completed on 09/01/2025 at 3:00 p.m.
- Fire Drill completed on 12/23/2025 at 10:00 a.m.
- Fire Drill completed on 04/10/2026 at 1:30 p.m.

On 05/11/2026 at approximately 2:45 p.m., Surveyor reviewed concern with Chief Operating Officer A, Administrator B and RN C that a fire drill was not completed during the first quarter of 2026 and that a fire drill simulating usual sleeping hours was not completed in 2025. Administrator B stated the former assistant administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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 525	Continued From page 26 completed drills and asked if the March 2025 drill would count as a drill simulating usual sleeping hours. Surveyor reviewed the time of drill and Administrator B then agreed that 4:58 p.m. would be around dinnertime and not similar to usual sleeping hours.	N 525		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions.	Z 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR OF DEFOREST	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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
Z 012	Continued From page 27 This Rule is not met as evidenced by: Based on record review and interview, the provider did not make a good faith effort to obtain a background check when a caregiver indicated s/he had resided out of state in the past 3 years on his/her background information disclosure (BID). The provider did not request a background check from the State of Pennsylvania, where Caregiver G had resided in the past 3 years. Findings include: On 05/11/2026 at 12:15 p.m., Surveyor reviewed employee records provided by Chief Operating Officer A. Caregiver G's record documented that s/he was hired on 07/31/2025. The record included a BID, dated 07/25/2025, that indicated Caregiver G had resided in the State of Pennsylvania within 3 years of hire. The record did not include a background check with Pennsylvania. On 05/11/2026 at approximately 12:30 p.m., Surveyor asked Chief Operating Officer A if the provider had completed a background check for Caregiver G with the State of Pennsylvania. Chief Operating Officer A replied, "That wasn't done. We're going to get a [deficiency] on that."	Z 012		