STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014846	A. BUILDING: _____ B. WING _____	C 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN PINES	343 E CUMBERLAND ST BERLIN, WI 54923

(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
M 000	INITIAL COMMENTS On 05/05/2026 with information gathered through 05/07/2026, Surveyor conducted an abbreviated survey and complaint investigation at Evergreen Pines, an Adult Family Home (AFH) in Berlin, WI. One deficiency identified. Complaint substantiated. Census: 4	M 000		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) received all prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 received a medication that was not prescribed to him/her. Findings include: On 03/19/2026, the Department received a complaint indicating resident's were not receive medications as prescribed.	M 462		

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

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M 462	Continued From page 1 On 05/06/2026 at approximately 10:00 AM, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted to facility on 09/14/2023 and had a guardian. -Resident 1's February 2026 MAR did not have an order for Clozapine. -Medication Error Report dated 02/26/2026 stated the following: "Date of error: 02/26/26. Type of error: wrong resident. Medication: Clozapine 100 MG. Explain reason for error: [Resident 1] took the 8:00 AM med. How was error discovered: when staff looked at the med cup it was taken. What precautions are being taken to prevent similar error? [Resident 1] went to room. Staff noticed [s/he] was sleeping, had a seizure." -Resident 1's Incident Report dated 03/04/2026 stated the following: "On 02/26/2026, [Caregiver B] was administering medications, when [s/he] put [Resident 2's] 8:00 AM medication in a plastic med cup and left it unattended. [Resident 1] grabbed the medication and took the medication that was in the med cup. In addition, [Caregiver B] administered [Resident 1's] 8:00 AM scheduled medications. [Caregiver B] did not do anything to ensure resident safety and well being. [Caregiver B] did not follow company protocol for situations such as this. [Caregiver B] had spoken to lead staff [Caregiver C], on two occasions and on the last call informed [Caregiver C] that [Resident 1] was not going to work that day as [s/he] was sleeping. ([Caregiver B] never mentioned anything about the medication). [Caregiver C] who is also [Resident 1's] guardian knew this was very unusual so [s/he] went over to Evergreen Pines. While en route to Evergreen Pines, [Caregiver C] received a phone call from [Resident 1's] day program stating that [Resident 2] told them that [s/he] did not get [his/her]	M 462		

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M 462	Continued From page 2	M 462		

medication and that [Resident 1] had taken [his/her] medication. [Caregiver C] arrived and observed [Resident 1] being pale in color, slumped over--sliding down the chair, not responding to stimuli/sound and [his/her] breathing was shallow. [Caregiver C] immediately called 911 and held [Resident 1's] head up to open [his/her] airway while standing in front of [him/her] so [s/he] would not slide off the chair. While talking to dispatch, [Caregiver C] and [Caregiver B] lowered [Resident 1] to the floor per dispatch so CPR could be performed if [Resident 1] stopped breathing. Paramedic's arrived shortly thereafter and took over. [Resident 1] was transported to Berlin Hospital where multiple tests were performed...EKG, Chest x-ray, blood work, UA and a CT scan on [his/her] head. [Resident 1] was admitted to the hospital overnight for observation. [Resident 1] was sedated heavily due to the medication [s/he] took. [Caregiver C] kept me informed as [s/he] knew things regarding [Resident 1]. I was informed by the police department, they would be pursuing criminal charges against [Caregiver B] for neglect as [s/he] admitted to knowing that [Resident 1] took medication that was not [his/hers] and that [Caregiver B him/herself] did nothing to ensure resident safety including but not limited to calling and reporting the incident."

On 05/07/2026 at approximately 10:30 AM, Surveyor interviewed Administrator A. Administrator A acknowledged Resident 1 received 100 mg of Clozapine that was Resident 2's medication. Administrator A stated s/he fired Caregiver B immediately and educated staff on the importance of reporting incidents to management immediately.