

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/17/2026
NAME OF PROVIDER OR SUPPLIER FAIRHAVEN CORPORATION		STREET ADDRESS, CITY, STATE, ZIP CODE 435 W STARIN RD WHITEWATER, WI 53190		
(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 08/17/2026, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Fairhaven Corporation located at 435 W Starin Road in Whitewater, WI. One citation of noncompliance was issued. The complaint was substantiated. Census: 45	N 000		
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 interview and record review, the provider did not ensure Resident 1's buprenorphine (Butrans; a narcotic medication) transdermal patch was administered, as prescribed. The findings are: The department received an allegation the facility did not administer Resident 1's medications, as prescribed. On 08/17/2026 at approximately 10:15 A.M., Surveyor received a list including the names of residents recently discharged from the facility from Facility Staff G. This list included Resident 1's name and discharge date "effective" on	N 352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 352	Continued From page 1 07/19/2026. Facility Licensed Practical Nurse (LPN) B told Surveyor Resident 1 was receiving palliative hospice services at the facility before being sent to a local emergency room approximately 1 or 2 days before discharge effective date. Facility LPN B said Resident 1 was sent to the emergency room "possibly" related to pain, as this was a reason for Resident 1's hospitalizations in the past. Facility LPN B said Resident 1 did not return to the facility. Facility LPN B said Resident 1 was hospitalized after being sent to the emergency room and later discharged to an inpatient hospice center where Resident 1 died. On 08/17/2026 at 10:51 A.M., Surveyor conducted an interview with Caregiver D. Caregiver D told Surveyor Resident 1 was able to transfer independently to his/her wheelchair and required full assistance from caregivers with activities of daily living prior to Resident 1's discharge from the facility. Caregiver D said Resident 1 was normally alert and oriented but experienced confusion just prior to being sent to the emergency room before his/her discharge. Caregiver D said Resident 1's confusion was unusual and a new issue for Resident 1. On 08/17/2026 at approximately 12:00 P.M., Facility LPN B and Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/20/2025 with multiple medical diagnoses including insulin-dependent diabetes, chronic heart failure, chronic kidney disease, and a history of cancer. Facility LPN B said Former Wellness Director/Registered Nurse (RN) C typically dealt with the oversight of Resident 1's medications and care services related to Resident 1 being more "medically complex." Resident 1's prescribed medications included	N 352		

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N 352	Continued From page 2 Butrans 5 micrograms per hour transdermal patch. The practitioner's order dated 06/10/2026 included, "Apply 1 patch transdermally [to skin] in the morning every Thu [Thursday] for pain." Resident 1's July 2026 medication administration record (MAR) included documentation of administration of Resident 1's Butrans transdermal patch, as prescribed, on Thursday, 07/09/2026 by Caregiver F and on Thursday, 07/16/2026 by Caregiver E. Facility LPN B told Surveyor the caregiver's/medication passer's initials on the Resident 1's MAR regarding administration of the Butrans transdermal patch implied removal of the previous patch and the application of a new patch. Facility LPN B said the caregivers did not "initial" the removal of the previous patch and administration of the new patch separately. Resident 1's progress notes included documentation dated 07/16/2026 at 10:40 P.M. including, "Writer assisted [Resident 1] with cares...[Resident 1] seemed a little confused tonight. [Resident 1] was not sure what was going on. [Resident 1] went right past the bathroom on the way to get cares done, on the way to bed [Resident 1] wasn't [sic] sure where bed was. [Resident 1] stated [s/he] was "all out of sorts."" Resident 1's progress notes included documentation dated 07/18/2026 at 6:32 A.M. including, "[Resident 1] was sent out to hospital around 0000 [midnight]. [Resident 1's Legal Representative H] wanted [Resident 1] to get sent out [to hospital] due to a possible UTI [urinary tract infection]. [Resident 1] was hallucinating and seeing people and hearing people in bedroom." On 07/27/2026, Surveyor received Resident 1's hospital discharge documentation. The	N 352		

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N 352	Continued From page 3 documentation included Resident 1 was admitted on 07/18/2026 and discharged on 07/20/2026. The documentation included, "[Resident 1] to emergency room from [facility] by EMS [emergency medical services] with report of "not acting [himself/herself]" and hallucinating the last "couple of days." [Resident 1's Legal Representative H] reports increased stool [bowel movement] that [facility] is attempting to manage. Duplicate patches found on [Resident 1] upon arrival in ED [emergency department]." The documentation included, "...[Resident 1] presented from assisted living facility via EMS for acute confusion and hallucinations over preceding several days. History was primarily obtained from [Resident 1's Legal Representative H] due to [Resident 1's] encephalopathy [confusion]. [S/he] reported [Resident 1] is normally fully oriented and cognitively intact but developed progressive confusion with visual hallucinations and delusional thoughts over the last 2 days. Yesterday (07/17/2026), [Resident 1] was unable to recall the name of the assisted living facility where [s/he] has resided for approximately one year. [Legal Representative H] also reported increased watery output from [his/her] ileostomy [a surgical opening in abdomen with external collection bag for stool] over the preceding several days and a productive cough present for approximately two weeks. Approximately one week prior to presentation, a [narcotic medication] patch had been started for chronic shoulder pain, and in the emergency department [Resident 1] was found to have two [narcotic medication] patches simultaneously in place (dated the 9th [07/09/2026] and 16th [07/16/2026], raising concern for opioid toxicity contributing to [his/her] altered mental status." The documentation included, "In the ED, duplicate [narcotic] patches were removed...	N 352			

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N 352	Continued From page 4 [Resident 1] was admitted to the ICU [intensive care unit] for vasopressor support [administration of medications to raise low blood pressure], management of severe sepsis with septic shock [infection causing life-threatening medical emergency], acute kidney injury, and acute metabolic encephalopathy." The documentation included, "[Resident 1] was admitted with severe sepsis and septic shock secondary to Pseudomonas urinary tract infection with concurrent community-acquired pneumonia." The documentation included, "Given [Resident 1's] advanced chronic medical conditions and overall poor prognosis...[Resident 1's] family elected to transition to comfort-focused care with hospice." On 08/17/2026 at approximately 1:00 P.M., Surveyor reviewed Caregiver E's employee record. Caregiver E's date of hire at the facility was 05/06/2026. Caregiver E's record included documented training of medication administration previously completed on 03/11/2021 and 08/03/2022. Caregiver E's record included documentation titled, "Nurse Delegation for CBRF Medication Passers" including Caregiver E's and Former RN C's signatures dated 07/01/2026. This delegation documentation included information regarding external topical medication, including transdermal patch application and removal, and controlled substances. The documentation included, "When removing old patch, fold patch in half with medication side inside." On 08/17/2026 at approximately 1:19 P.M., Facility LPN B told Surveyor s/he did not recall being made aware Resident 1 had 2 Butrans patches on his/her person when sent to the hospital's emergency room on 07/18/2026.	N 352		

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N 352	Continued From page 5 Facility LPN B said s/he was not able to find documentation of nor was s/he aware of any medication error reports related to Resident 1's Butrans transdermal patch during June and July 2026. On 08/17/2026 at 1:34 P.M., Surveyor conducted an interview with Caregiver E. Caregiver E told Surveyor 07/16/2026 was the first day s/he had "passed" medications on the floor in which Resident 1 resided at the facility and s/he "did not know what [s/he] was doing." Caregiver E told Surveyor s/he did not administer the Butrans transdermal patch to Resident 1 on 07/16/2026, despite his/her documentation of administration within Resident 1's July MAR. Caregiver E said s/he gave Resident 1's Butrans narcotic transdermal patch to a caregiver that was going to assist Resident 1 with cares that morning and that caregiver was to put the patch on Resident 1. Caregiver E said s/he did not recall who the caregiver was and Caregiver E did not check to ensure the new patch was applied to Resident 1 and/or to ensure the previous patch applied on 07/09/2026 was removed. Caregiver E told Surveyor the facility medication passers usually gave topical medications, including transdermal patches, to the caregivers to administer while assisting with resident cares. On 08/17/2026 at approximately 2:00 P.M., Surveyor conducted an interview with Administrator A and Facility LPN B. Both Administrator A and Facility LPN B told Surveyor they were not aware the caregiver's responsible for administering resident medications were giving any medications, including transdermal patches, to caregivers providing resident cares to perform that medication's administration. Facility LPN B told Surveyor the facility management	N 352			

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N 352	Continued From page 6 would establish and document a plan to ensure proper removal of transdermal patches was being completed and documented. Facility LPN B said facility management would establish and document a plan to ensure proper disposal of used/removed narcotic transdermal patches. Facility LPN B said facility management would immediately ensure caregivers responsible for administering medications to residents were administering medications as prescribed and not delegating that task to other caregivers to complete. Facility LPN B said training regarding proper medication administration and documentation would be provided to caregivers. Administrator A said s/he would have expected Former RN C to document a medication error investigation if s/he were made aware of Resident 1 having 2 Butrans transdermal patches on his/her body at the same time. On 08/17/2026 at 4:13 P.M., Surveyor conducted an interview with Former RN C. Former RN C said his/her last day of employment at the facility was approximately 07/24/2026. Former RN C said s/he recalled watching Caregiver E perform medication administration and signed his/her delegation documentation. Former RN C said s/he believed Caregiver E had medication administration training prior to being hired by the facility. Former RN C told Surveyor s/he was not made aware by anyone, including the hospital emergency room staff, that Resident 1 had 2 Butrans transdermal patches on his/her body when s/he arrived at the emergency room on 07/18/2026. Former RN C said s/he expected all medication passers to apply transdermal patches, including narcotic patches, directly to residents, as prescribed, and not give them to other caregivers to apply. Former RN C said s/he was not aware of this practice when s/he worked at	N 352		

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N 352	Continued From page 7 the facility. Summary: The provider did not ensure Resident 1's buprenorphine (Butrans; a narcotic medication) transdermal patch was administered as prescribed.	N 352			