STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014850	A. BUILDING: _____ B. WING _____	R-C 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN NORTH RCAC	**320 SUPERIOR AVENUE WASHBURN, WI 54891**

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{U 000}	INITIAL COMMENTS On 05/07/2026, Surveyor began a complaint investigation, a verification visit, and a standard licensure survey at Birch Haven North RCAC. Data was collected through 05/12/2026. One of 2 complaints were substantiated. The violations from Statement of Deficiencies P97M15 were corrected. Two new violations were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 11	{U 000}		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician	U 267		

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

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U 267	Continued From page 1 and to refuse medication unless there is a court order. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure all tenants had the right to receive medications as prescribed. Tenant 1's medications were left out in his/her apartment, and s/he did not receive assistance with receiving them per his/her service agreement. Findings include: On 03/11/2026, the Department received a complaint regarding medications. On 05/07/2026, Surveyor reviewed records for Tenant 1, admitted 06/17/2024. The records included: - Tenant 1's comprehensive assessment, dated 06/17/2024. The comprehensive assessment read, in part, "...Medications and ability to self-administer medications: Staff will administer..." - Tenant 1's nursing plan of care, last updated 02/06/2026. The plan of care listed Tenant 1's diagnoses, which included Parkinson's disease and dyskinesia. - Tenant 1's initial service plan, dated 06/17/2024. The initial service plan indicated Tenant 1's medications were to be administered by a registered nurse, a licensed practical nurse, or a care provider daily and as needed per physician orders. - A daily note, dated 03/26/2026, which read, in part, "[Adult Child C] stops to speak with writer and we talk [sic] about medication compliance -	U 267		

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U 267	Continued From page 2 MAR [medication administration record] updated for staff to watch [Tenant 1] take [his/her] pills, document refusals and not to leave any meds (medications) in room. [Adult Child C] is part of developing this plan as is [Tenant 1]..." - Tenant 1's MAR from March 2026. Two notes were handwritten on the MAR and read, in part, "Do not leave meds in room" and "watch [Tenant 1] take meds and document refusals..." - Tenant 1's MAR from April 2026. A note was handwritten on the MAR and read, in part, "watch [Tenant 1] take meds/document refusals..." At approximately 3:14 PM, Surveyor interviewed Caregiver D. Caregiver D stated there were "probably certain people" who had left medications in Tenant 1's room without ensuring Tenant 1 had taken the medications. At approximately 3:33 PM, Surveyor interviewed Licensee B. Licensee B stated approximately 3 weeks prior, Adult Child (AC) C had called Licensee B regarding Tenant 1's medication administration. Licensee B stated Caregiver E had left medications in Tenant 1's room without ensuring administration, despite having been specifically instructed not to do so. Licensee B showed Surveyor a text message thread between Licensee B and AC C, dated 03/06/2026. The text messages indicated AC C had sent photos of medication cups with several medications left in them. AC C had indicated in a text message that s/he had found the medications left out in Tenant 1's apartment, and that s/he had found a dose of Tenant 1's melatonin in a napkin. The text message indicated Caregiver E had left the melatonin in Tenant 1's room due to Tenant 1 refusing it. At approximately 4:10 PM, Surveyor interviewed	U 267		

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U 267	Continued From page 3 AC C. AC C stated s/he had found medications left out in Tenant 1's apartment in the past. AC C stated s/he would come in regularly to ensure Tenant 1 was receiving his/her medications in the mornings. On 05/08/2026, Surveyor received an email from Licensee B. The email included a document titled, "[Facility Name]: Employee Progressive Discipline." The document, dated 03/06/2026, indicated Caregiver E had been under disciplinary review for not administering medications to Tenant 1. The document read, in part, "Written Warning...I received a complaint and pictures from [AC C] concerning [Caregiver E]. [AC C] entered [Tenant 1's] apartment and found [Tenant 1's] med cup sitting on the kitchen table with [Tenant 1] sleeping in [his/her] bed. Specific instructions had been given several months ago that meds were NOT to be left for [Tenant 1] as [s/he] would not always take the medication or would have difficulty taking them r/t [related to] [his/her] Parkinsonian [sic] symptoms. When questioned about this... [Caregiver E] became argumentative an offered a myriad of excuses as to why the medications were left. In my speaking with [Caregiver E] about this [s/he] admitted to leaving the meds...I explained that medication administration orders were just that, orders, and could NOT be altered by [Caregiver E] for ANY reason. In this case, the order was to OBSERVE the Resident taking ALL medications and specifically NOT to leave meds sitting in his apartment...The expectation was that [Caregiver E] will follow all medication administration orders completely and there was NO exceptions to this. If a Resident was sleeping, they were to be either woken up or in the event that the Resident could NOT be woken up, the nurse or manager should be called to see what options were available..."	U 267		

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U 267	Continued From page 4 The provider did not ensure all tenants received their prescribed medications.	U 267		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a background information disclosure (BID) form, a criminal history check from the department of justice (DOJ), or information contained in the governmental findings report (GFR) as required. One of 3 employees sampled did not have a complete criminal history check done prior to working or every 4 years. Findings include: On 05/07/2026, Surveyor reviewed employee records for Caregiver A, hired in 2018. Caregiver A's record included a BID form, dated	Z 022		

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Z 022	Continued From page 5 11/28/2018. Caregiver A's record did not include any other BID form. Caregiver A's record included a DOJ criminal history search report, dated 07/25/2019. Caregiver A's record did not include any other DOJ criminal history report. Caregiver A's record included a GFR from the Department of Health Services (DHS), dated 07/25/2019. Caregiver A's record did not include any other GFR. At approximately 2:24 PM, Surveyor interviewed Licensee B. Licensee B stated s/he did not think a complete background check had been completed for Caregiver A since his/her original one had been completed. On 05/08/2026, at approximately 8:31 AM, Surveyor received an email from Licensee B. The email read, in part, "...[Caregiver A]...we do not have an updated [background check]..." The licensee did not ensure BID forms, DOJ criminal history checks, and DHS GFR were completed prior to working and every 4 years by each caregiver.	Z 022		