STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020787	A. BUILDING: _____ B. WING _____	C 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR ASSISTED LIVING OF RIVER FA	119 UNION STREET RIVER FALLS, WI 54022

(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
U 000	INITIAL COMMENTS On 03/11/2026, Surveyor conducted a complaint investigation at Bay Harbor Assisted Living of River Falls. One of 1 complaint was substantiated. One violation was identified. Census: 58	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 and to refuse medication unless there is a court order. This Rule is not met as evidenced by: Based on record review and interview, the	U 267		

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

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U 267	Continued From page 1 provider did not ensure 3 of 5 tenants had the right to receive all medications as prescribed. Findings include: On 01/06/2026, the Department received a complaint about medications. On 03/11/2026, Surveyor reviewed records for Tenant 1, Tenant 2, and Tenant 3. Tenant 1's records included: - An observation note, dated 01/05/2026, which indicated a medication error incident report had been completed for Tenant 1 by Director of Nursing (DON) A. - A medication pass record, dated from 12/01/2025 to 01/31/2026, which indicated that Tenant 1 was to be administered 15 milligrams (mg) of rivaroxaban daily in the evening and 3 mg of melatonin daily in the evening. The record indicated that on 01/18/2026, Tenant 1's daily doses of rivaroxaban and melatonin were not administered. The record read, in part, "had no meds to give..." under the entries for both Tenant 1's rivaroxaban and his/her melatonin. - An observation note written by a staff member, dated 01/17/2026, which read, in part, "...bubble packs of [rivaroxaban] and Melatonin [sic] are completely done, finished 1/17/2026. I looked in the desk drawer, and I did not find anything..." - A medication error incident report, dated 12/30/2025, which read, in part, "Staff called RN [registered nurse] stating that tenant received [his/her] AM meds [medications] last evening instead of the PM meds. It was discovered that the PM and AM meds were switched in the [medication planning organizer]..."	U 267		

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U 267	Continued From page 2 Tenant 2's records included: - A medication pass history, dated from 12/01/2025 to 01/31/2026, which indicated Tenant 2 was to be administered 100 mg of sertraline daily in the morning. The record indicated that on 01/04/2026, Tenant 2's daily dose of sertraline was not administered. The note under the daily dose of sertraline read, in part, "not available..." - An observation note, dated 01/04/2026, read, in part, "Tenant complained of severe depression and loneliness to the writer 3 sperate [sic] times during the evening. Stated that [s/he] had been crying all afternoon and is very upset about the inability to take [his/her] sertraline this morning. Tenant stated that [s/he] knows nothing else will help and that nothing can be done this evening but would like to be notified as soon as possible as to when they will be getting the medication again..." Tenant 3's records included: - A medication pass history report, dated from 12/01/2025 to 01/31/2026, which indicated Tenant 3 was to be administered 10 mg of suvorexant in the evening on 12/18/2025. The medication error report indicated that on 12/18/2025, Tenant 3's suvorexant was not administered. The note on the entry read, "not available..." - An observation note by DON A, dated 12/18/2025, which read, in part, "[suvorexant] not available due to insurance. Provider updated. Requested a substitute..." On 03/11/2026, from approximately 11:00 AM to 11:47 AM, Surveyor interviewed Executive Director (ED) B. ED B stated s/he knew there had been an issue with getting medications to tenants. ED B stated it had been difficult for staff	U 267		

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U 267	Continued From page 3	U 267		

to follow the direction of DON A and that DON A made mistakes such as medication errors. ED B stated there might have been occasional issues with the pharmacy where medications were not ordered.

From approximately 12:32 PM to 1:20 PM, Surveyor interviewed DON A. DON A stated there might have been a few times tenants went without medications that winter.

Regarding Tenant 2's sertraline on 01/04/2026, DON A stated Tenant 2 had not been administered sertraline due to the medications being locked in the cabinet in his/her office and staff could not access it. DON A stated s/he kept overstock of medications in the locked cabinet and would fill medication planning organizers 1 time a week. DON A stated s/he might have forgotten to put Tenant 2's sertraline in the medication planning organizer. DON A stated if staff needed to access his/her locked cabinet, s/he would usually come in from home to unlock it for them. DON A stated s/he could not remember why the issue had not gotten resolved that day. DON A stated since then, s/he had been very careful.

Regarding Tenant 1's rivaroxaban and melatonin on 01/18/2026, DON A stated either staff had called him/her, and s/he had found it for them, or s/he did not have the medications from the pharmacy. DON A then stated that the pharmacy had called Tenant 1 directly, who had told the pharmacy s/he did not want the medication. DON A stated Tenant 1's family then picked up Tenant 1's medication, and it may have been delayed.

Regarding Tenant 3's medications, DON A stated Tenant 3 had run out of senna due to the

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U 267	Continued From page 4	U 267		

pharmacy sending Tenant 3's refill request to the wrong doctor and it took longer than expected to get to the facility. DON A stated staff did not tell him/her that Tenant 3's suvorexant was in low stock. DON A stated extra time was needed for the medical provider to get the medications to him/her, and it took a few days for them to find an alternate medication for Tenant 3.

Regarding the medication error report dated 12/30/2025, DON A stated somehow the medication planning organizer's AM and PM slots had been switched. DON A stated s/he could see how it may have happened if it was his/her fault.

DON A stated s/he had told staff they needed to let him/her know when tenant medications were in low stock. DON A stated a staff member had responded by saying they thought that it was DON A's job to keep track of low medications. DON A stated the medication issues were due to miscommunication.

At approximately 1:21 PM, Surveyor interviewed Staff Member (SM) C regarding the medication error report, dated 12/30/2025. SM C stated s/he had discovered the error on 12/31/2025 when s/he observed Tenant 1's AM and PM slots in the medication planning organizer were switched. SM C stated s/he knew the difference between Tenant 1's AM and PM medications, and that Tenant 1 must have been administered AM medications in the evening the day prior.

At approximately 1:40, Surveyor interviewed ED B, who stated the facility managed medications for Tenant 1, Tenant 2, and Tenant 3.

The provider did not ensure that all tenants received medications as prescribed.

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