

Wisconsin Department of Health Services

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0008920</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BAY HARBOR II</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3136 LONGVIEW LN BLDG B<br/>SUAMICO, WI 54173</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| N 000                                                    | Initial Comments<br><br>On 06/24/2025, Surveyor conducted an abbreviated survey at Bay Harbor II. As a result of the survey, 1 deficient practice was identified.<br><br>Census: 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | N 000                                                                                         |                                                                                                                          |                                                        |
| N 320                                                    | 83.29(4) Admission agreement not in conflict<br><br>Conflict with this chapter. No statement of the admission agreement may be in conflict with any part of this chapter, unless the department has granted a waiver or variance of a provision of this chapter.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the provider did not ensure all statements in the admission agreement were in compliance with Chapter 83. The admission agreement contained house rules that were not congruent with resident rights as defined in Chapter 83.<br><br>Findings include:<br><br>On 06/26/2025 at approximately 1:45 PM, Surveyor reviewed a copy of the admission agreement which included house rules. Surveyor identified statements within the document that were not congruent with resident rights and required removal or modification of the language to be in compliance with the code. Examples of statements/ rules that were identified as not in compliance with the code:<br><br>"3. For security and safety reasons residents are not permitted outdoors between 10:00 PM and 6:00 AM. | N 320                                                                                         |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                             |                                                                                                                          |                          |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0008920</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BAY HARBOR II</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3136 LONGVIEW LN BLDG B<br/>SUAMICO, WI 54173</b>                            |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| N 320                                                    | <p>Continued From page 1</p> <p>4. Visitors will be asked to leave the building by 10:00 PM unless approved by management prior to visit ...</p> <p>10. Residents are permitted to make personal phone calls using the facility phone ... if they do not have their own phone ... phone usage will be limited to 15 minutes ... Phone use is between the hours of 8:00 AM to 9:00 PM ...</p> <p>12. No resident shall be in the kitchen without prior authorization ..."</p> <p>On 06/26/2025 at approximately 2:00 PM, Surveyor reviewed the identified statements within the admission agreement with Director A who verified his/her understanding of why the areas identified needed to be modified or removed. Director A had no questions and was in agreement that the statements identified needed to be modified or removed. Director A stated the changes would be made and the admission agreements updated to reflect the changes.</p> | N 320                                                                       |                                                                                                                          |                          |                                                        |