STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016473	A. BUILDING: _____ B. WING _____	C 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDEMERE BIRCH HOUSE	2999 RIVERSIDE DR GREEN BAY, WI 54301

(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 A complaint investigation was conducted at Wyndemere Birch House on 09/02/2026 with information gathered through 09/03/2026. As a result of this investigation, the complaint was substantiated and 2 deficiencies were identified. One (1) of 2 deficiencies was a repeat violation. Census: 15	N 000		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and staff and resident interviews, the provider did not ensure the medication cart had the key available only to personnel. On 09/02/26, Surveyor observed the med cart in the front lobby next to the dining room with the keys hanging in the lock and unattended from 9:30 AM to 9:35 AM. Three (Residents 3, 4 and 5) of 15 residents were in the area near the unsecured med cart with no staff visible. This is a repeat violation. See Statement of Deficiency (SOD) ENWE12, dated 08/15/2022. Findings include: On 09/02/26 at 9:30 AM, Surveyor observed the medication cart in the front lobby next to the dining room with the keys hanging in the lock and unattended. Residents 3, 4 and 5 were in the area near the medication cart. Surveyor asked Resident 3 if s/he knew where the staff were. Resident 3 who was sitting in the dining room	N 419		

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

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N 419	Continued From page 1 near the medication cart, stated CG - C left to help Resident 6 who just called for help and s/he is the only person on. Surveyor noted Residents 4 and 5 sitting by a table on the other side of the medication cart during this time. On 09/02/2026 at 9:35 AM, WC (Wellness Coordinator) D entered the building and removed the keys from the unattended med cart. WC - D confirmed to Surveyor the medication cart should not have the keys hanging in it. WC - D said the current staff passing medications was CG (Caregiver) - C. At approximately 9:45 AM, CG - C told Surveyor s/he was the only staff in the building at the time but another caregiver from one of the sister buildings had just come over to help. CG - C said before the extra help came over, CG - C was about to pass a medication when Resident 6 was trying to get up unassisted so s/he ran to help prevent a fall. CG - C said his/her concern was for Resident 6 and s/he wasn't thinking about the keys hanging in the medication cart. CG - C said s/he is aware the cart should not have the keys left in it.	N 419		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and staff and resident interviews, the provider did not ensure that bathroom fixtures and floors as well as shower room fixtures were clean and in good working order having the potential to affect all 15 residents. Resident bathrooms, toilets, and	N 490		

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N 490	Continued From page 2	N 490		

flooring were found to have urine, feces, and odors and an uncleanable floor. The shower room had black mold around the base, missing plaster, the vanity coming off the wall, and a sink that did not fully fit the vanity opening.

Findings include:

On 09/02/2026, Surveyors toured the facility checking resident bathrooms and showers in response to concerns sent to the State Agency. Observations by Surveyors from 10:00 AM to approximately 1:00 PM identified the following:

1. The bathroom shared by Resident's 1 and 2 had feces on the toilet seat, urine on the front base of the toilet, a urine odor, and the flooring had been removed and was a rough textured, uncleanable surface.

2. The shared shower room across from room 10 had a black-like substance resembling mold in the grout surrounding the base of the shower, the vanity top coming off the wall, the sink did not fit the vanity leaving a 1/2 inch gap, plaster was missing on the wall near the shower approximately 3 feet long by 1 inch wide.

3. The bathroom shared by Resident 7 and vacant room 2 had urine on the floor by the toilet and odors of urine and uncleanliness.

In an interview with Surveyor on 09/02/2026 at 10:55 AM, Resident 2 indicated s/he shared a bathroom with Resident 1. Resident 2 indicated the bathroom is not clean and had an odor so they (management) pulled the floor out but it stayed that way.

During an interview with Resident 7 on

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N 490	Continued From page 3 09/02/2026 at 11:00 AM, s/he stated his/her bathroom has not been cleaned in over a week and "it needs a cleaning bad." Resident 7 reported, "They (staff) come in and out and see it, and don't do anything about it." On 09/02/2026 at 2:25 PM, Surveyors interviewed Director of Wellness (DW) A and Administrator (ADM) B who acknowledged Surveyors concerns. DW A reported they were waiting on approval to replace the flooring in Resident 1 and Resident 2's shared bathroom. S/he stated s/he will need to follow up with their maintenance director, but there are plans to have it replaced.	N 490		