STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019869	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR MEMORY CARE ASSISTED LIVING OF	1936 TENNYSON LN MADISON, WI 53704

(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 From 02/13/2024 to 02/23/2024, Surveyor completed 2 complaint investigations at Bay Harbor Memory Care Assisted Living of Madison, a CBRF in Madison. One deficiency was identified. The complaints were substantiated. Census: 43	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed received prompt and adequate treatment that was appropriate to the resident's needs. Resident 2 sustained a fall sometime between 4:00 a.m. and 5:30 a.m. but did not arrive to the hospital for treatment until approximately 9:30 a.m. Resident 1 had to wait for his/her family member to come to the facility to provide urostomy cares due to staff being unable to perform the care. Findings include: From 02/13/2024 to 02/23/2024, Surveyor conducted a complaint investigation alleging that the facility did not meet the needs of residents. The following concerns were identified:	N 353		

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

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N 353	Continued From page 1 Example 1 - Resident 2: On 02/13/2024 at approximately 11:15 a.m., Surveyor interviewed Caregiver B. Caregiver B stated Resident 2 had a history of falling. Caregiver B stated Resident 2 resided on the 3rd floor of the facility, which had limited staffing. Caregiver B explained that the 3rd floor and 4th floor did not have dedicated caregiver on the floor at all times, but rather a 1st floor caregiver was expected to "float" to 3rd and 4th floors to provide cares. On 02/13/2024 at approximately 11:45 a.m., Surveyor interviewed Caregiver F. Caregiver F stated Resident 2 had a fall recently and was found in his/her own vomit. Caregiver F didn't know further details. On 02/13/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 01/11/2024 with diagnosis including Parkinson's disease. Resident 2's record included a fall report, dated 02/11/2024 at 10:02 p.m., that stated "On 02/11 I did my rounds at approximately 4:30 a.m., [Resident 2] was in bed. I went back there at approximately 5:30 a.m. to get [him/her] up and ready for the day and that is when I saw [Resident 2] on the floor in a fetal position on [his/her] left side. [His/her] wrist was bent backwards under the side of [his/her] body, [his/her] knees were badly scraped up, and [his/her] face was swollen. [His/her] hand and wrist was also swollen. It looked as if [s/he] tried to go to the bathroom and change [his/her] depend as [his/her] depend was down under [his/her] buttocks. I picked [him/her] up sat [him/her] on the bed and proceeded to call	N 353		

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[Wellness Director C]. I then cleaned [him/her] up, cleansed and bandaged [his/her] wounds, I also performed range of motion on [his/her] left wrist and hand as well as [his/her] left hip and leg. I then elevated [his/her] arm and informed AM shift what happened, they called [his/her] POA and [his/her] POA suggested [s/he] go to the hospital." The incident report was completed on 02/11/2024 at 10:02 p.m., greater than 12 hours after the fall occurred.

On 02/20/2024 at approximately 3:00 p.m., Surveyor reviewed hospital records, dated 02/11/2024, which documented Resident 2 arrived to the hospital at approximately 9:30 a.m. The report stated Resident 2 was found by facility staff at approximately 4:00 a.m. in a "pretzel like position" with vomit on the floor and that Resident 2 reported s/he fell at 12:00 a.m. The report stated Resident 2 sustained injures to his/her knees and had elbow swelling. The report stated Resident 2 was found to have pressure ulcers to bilateral knees and was evaluated for rhabdomyolysis given his/her prolonged downtime. Evaluation concluded Resident 2's CK (creatine kinase) was moderately elevated, consistent with rhabdomyolysis. The report indicated Resident 2 received intravenous fluids. After reviewing the hospital record, Surveyor reached out to Administrator A regarding the time of Resident 2's fall and the amount of time that passed from the time of the fall to the time Resident 2 was seen at the hospital.

"Rhabdomyolysis is a condition that causes your muscles to break down (disintegrate), which leads to muscle death. When this happens, toxic components of your muscle fibers enter your circulation system and kidneys. This can cause kidney damage. ... Causes of rhabdomyolysis

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include: ... long periods of inactivity: People who fall, lose consciousness, and can't get up for an extended period can develop rhabdomyolysis." (Source: Cleveland Clinic Website, Rhabdomyolysis, February 24, 2023, https://my.clevelandclinic.org/health/diseases/21184-rhabdomyolysis (retrieval date - February 21, 2024).)

On 02/21/2024 at approximately 2:00 p.m., Administrator A stated Resident 2 was found on the floor at 5:30 a.m. and was not on the floor when the caregiver had checked on Resident 2 at 4:30 a.m. Administrator A stated the night shift caregiver instructed daytime staff to contact Resident 2's Health Care Power of Attorney (HCPOA). Administrator A stated daytime staff contacted the HCPOA, who requested Resident 2 be sent out and there was a time lapse from when paramedics arrived. Administrator A did not provide a timeline of the events.

On 02/22/2024 at approximately 12:00 p.m., Surveyor reviewed a paramedic report, dated 02/11/2024, that stated, "Nurse stated [Resident 2] was found on the floor by day shift 'like a pretzel' with arms and legs wrapped. Nurse stated there was vomit found on the floor next to [him/her]. Nurse stated [Resident 2]'s arm was swollen more than usual. The report indicated paramedics were contacted for assistance at 7:43 a.m.

On 02/23/2024 at approximately 3:00 p.m., Surveyor interviewed Administrator A regarding Resident 2's fall. Surveyor reviewed the following concerns:

- Hospital report indicated Resident 2 fell at approximately 12:00 a.m.

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- Resident 2 was tested for rhabdomyolysis due to prolonged downtime and test results were consistent with rhabdomyolysis diagnosis.
- Paramedic report documented daytime staff found Resident 2 down.
- Paramedics were not contacted until 7:43 a.m., when Resident 2's fall occurred sometime between 12:00 a.m. and 5:30 a.m.
- The incident report was completed on 02/11/2024 at 10:02 p.m., so exact time notifications were made was not documented.

Administrator A acknowledged the inconsistencies between hospital records, paramedic report and staff reports. Surveyor asked if a nurse completed an assessment following Resident 2's fall. Administrator A replied, "No." Administrator A stated caregivers were instructed to contact the HCPOA and confirmed the HCPOA requested to have Resident 2 sent to the hospital. Administrator A stated there was then a delay from the time the lead caregiver contacted paramedics to have Resident 2 sent to the hospital. Administrator A agreed that there was a delay in getting Resident 2 treatment and stated the facility had taken disciplinary action due to the occurrence.

Example 2 - Resident 1:

On 02/13/2024 at approximately 11:15 a.m., Surveyor interviewed Caregiver B. Caregiver B identified Resident 1 as a resident that required urostomy cares. Caregiver B stated s/he recently worked a weekend when Resident 1 was found with his/her bed soaking wet. Caregiver B stated Resident 1's urostomy bag had come off and s/he didn't know how to replace it. Caregiver B stated s/he contacted Wellness Director C, who directed

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Caregiver B to have other staff provide assistance. Caregiver B stated his/her co-workers were unsure what to do, so they contacted Resident 1's family member who ended up coming in and providing the cares. Surveyor asked Caregiver B if s/he received training from the provider for urostomy cares. Caregiver B stated s/he watched a video on cares but was never shown how to complete the cares and the provider did not follow up to evaluate Caregiver B's understanding of the cares.

On 02/13/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 01/11/2024. Resident 1's individual service plan (ISP), 02/13/2024, stated staff were to empty Resident 1's urostomy bag 4 times daily and notify the nurse on call if the urostomy bag needed to be changed.

On 02/13/2024 at approximately 1:00 p.m., Surveyor interviewed Wellness Director C. Surveyor asked if Resident 1's family had ever had to come in to care for Resident 1's urostomy. Wellness Director C replied, "No." Wellness Director C stated there was always a caregiver present that was able to care for Resident 1's urostomy. Wellness Director C did recall being contacted by caregivers that stated Resident 1's urostomy needed to be changed, but that there was a caregiver on shift capable of completing the cares, so Wellness Director C instructed caregivers to have that caregiver complete Resident 1's urostomy change.

On 02/15/2024 at approximately 3:00 p.m., Surveyor interviewed Caregiver D. Caregiver D stated s/he worked 02/02/2024. Caregiver D stated a "newer" caregiver was working with

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N 353	Continued From page 6 Resident 1 when Resident 1's urostomy bag was coming off and the caregiver did not know how to care for the urostomy. Caregiver D stated s/he was on a different floor and too busy to help. On 02/15/2024 at approximately 3:50 p.m., Surveyor interviewed Caregiver E. Caregiver E stated on 02/02/2024 Resident 1's urostomy bag was pulling away from the skin and Caregiver E could not get the bag reapplied. Caregiver E stated on-call staff was contacted and assistance requested, but after no one responded, caregivers called Resident 1's family member to come in and provide assistance. Caregiver E stated s/he had not received adequate training for Resident 1's urostomy bag by the facility's staff, but that Resident 1's family member provided instruction. On 02/23/2024 at approximately 3:00 p.m., Surveyor reviewed concern with Administrator A and Wellness Director C regarding 02/02/2024 occurrence when staff were unable to complete Resident 1's urostomy caress, family came in and provided care. Administrator A had no follow up questions or comments.	N 353		