STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019111	A. BUILDING: _____ B. WING _____	C 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYVIEW SENIOR CARE LLC	839 S 18TH AVE STURGEON BAY, WI 54235

(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 On 02/14/2025, Surveyors conducted a complaint investigation at Bayview Senior Care LLC in Sturgeon Bay. On 02/27/2025, an additional onsite visit was conducted to gather additional information. Information has been gathered through 03/12/2025. As a result, 2 of 3 complaints were substantiated and 2 deficiencies were identified. Census: 47	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on record review, interview and observation, the provider did not ensure a safe environment for 1 of 1 residents reviewed. Resident 1 eloped from the facility on 01/28/2025 and was located by a citizen in the community. Findings include: The provider is licensed to care for up to 70 residents in the following client groups: advanced age, physical disabilities, irreversible dementia/Alzheimer's and terminally ill.	N 358		

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

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N 358	Continued From page 1 On 01/30/2025, the Department received a complaint with concerns about resident elopements from the facility. On 02/14/2025 and 02/27/2025, Surveyors conducted onsite visits to the facility. On 02/14/2025, Surveyors observed 2 sets of doors to enter the facility. Both sets were automatic sliding doors. Surveyors observed no alarms associated with the doors opening and/or closing. On 02/14/2025 at approximately 11:04 AM, while in Resident 2's room, accompanied by Resident Assistant U, another caregiver and Resident 2, Surveyor observed a pager, that Resident Assistant U had on them alarm. Resident Assistant U reached down to the pager and silenced it. Resident Assistant U stated out loud, "Not now, we are busy, you will have to wait." Resident Assistant U did not identify if the pager alert was from a resident or one of the door alarms. Resident Assistant U continued to assist the other caregiver with changing Resident 2 in their bed. Surveyor left Resident 2's room to allow for privacy. On 02/27/2025 at approximately 10:40 AM, Surveyors interviewed Resident Assistant U while observing the front doors to the facility. Resident Assistant U explained when someone walks through the front doors, an alert is sent to the pager (each staff member carries a pager). The alert indicates the front door has opened but does not indicate who is coming or leaving the facility. Resident Assistant U stated when the pager goes off and indicates the front door is opened, staff are to respond to the front door and staff need to	N 358		

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N 358	Continued From page 2	N 358		

type in a code to clear the system. If staff do not clear the system, the pager will continue to alert staff. Surveyors asked Resident Assistant U to demonstrate how the front door alarm works. One Surveyor walked through the front doors, while the other Surveyor observed Resident Assistant U's pager. As the Surveyor walked through the front doors, Resident Assistant U's pager did not activate for approximately 30 seconds after Surveyor walked through the front door. Once the pager activated, the pager read, "front door" "wandering" with a date and time of 01/14/2022 at 6:25 AM. Resident Assistant U stated the time and date are not accurate. Resident Assistant U then went over to the front doors, entered a code on the wall panel and the pager was cleared.

On 02/14/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/27/2025 as a respite resident and had a diagnosis of dementia. Resident 1 was discharged on 01/28/2025. Resident 1's Individual Service Plan (ISP) printed 02/14/2025 noted s/he was ambulatory and independent with activities of daily living. Resident 1's pre-admission assessment completed on 12/27/2024 by Nurse J reflected "memory impair: - 8 yr. ago - Dementia...needs cues for tasks...does 2 walks a day." In addition, the pre-admission assessment reports Resident 1 is oriented to self, capable of making his/her own decisions, needs frequent cues for time and is familiar with places, but "if @ hotel writes room # on hand [sic all]."

On 02/14/2025, Surveyor reviewed a facility document titled, "[Resident 1] January 28, 2025 Elopement." The document did not include a facility member's signature or date. The document stated, "On January 28, 2025 [Resident 1] eloped from Bayview Senior Care.

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N 358	Continued From page 3 APS (Adult Protective Services) received a call from [Hospital E] notifying them that [Resident 1] was at the hospital. APS then contacted Bayview Senior Care to notify them (speaking to the AD A). Prior to the elopement, [Resident 1] was last seen walking down the halls around 9:30 AM. [Resident 1] was on 2 hour safety checks, and was coming up on [his/her] next safety check when staff received the call from APS...APS returned the resident to Bayview, and upon return the resident was put on 30 minute safety checks..." On 02/14/2025, Surveyor reviewed an attachment to the facility's internal investigation, which indicated Health Unit Coordinator G stated the following: "On January 28th, 2025- Writer came on shift at 2 a.m. Resident was up all night wandering the halls. Resident went down to wing 1 and had snack with another resident and [s/he] sat down on wing 1 till breakfast time. Resident then came to the big dining room and ate breakfast at 7:30 a.m. Writer did safety check on resident at 8:30 a.m. [S/He] was sitting in [his/her] room. Writer was walking down the hall and seen resident between 9 and 9:30. [S/He] was walking the hallway. Resident got called down to the dining room at lunch and was told resident was at the hospital." (Surveyor note: There was no mention whether or not the staff received a pager alert.) On 02/17/2025, Surveyor reviewed a police report from 01/28/2025. This report read in part: "On January 28, 2025 at approximately 0935 hours, [Officer B], was dispatched to [Police Department I]...for a citizen assist. Upon arrival I met with the elderly [fe/male] who	N 358		

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identified [him/herself] [Resident 1], who was brought in by a good Samaritan after being found wandering the streets near [Hospital E]. Upon meeting [Resident 1], [s/he] appeared confused and discussed unrelated topics. I asked [Resident 1] if I could contact any family members and [s/he] began to talk about a parking lot and where the gal [sic] may have parked and about landscaping. I asked [Resident 1] grabbed an application for the Department of Transportation that was inside the police department lobby area and stated [s/he] needed the paperwork for the place [sic all]. [Resident 1] seemed to exhibit signs of dementia, so I asked [Sergeant C] to assist in sitting with [Resident 1] while I investigated with Adult Protective Services.

I spoke with on-call [Worker D], who confirmed [Resident 1's] psychiatric history, including bipolar disorder and cognitive issues. [Worker D] advised transporting [Resident 1] to [Hospital E] for evaluation, to which [s/he] consented. I safely transported [him/her] to the hospital, where [Worker D] would meet us...

At the hospital, I learned that [Resident 1] is married to [Spouse F], who typically travels to Florida for the winter while a caregiver attends to [him/her]. [Resident 1] has a history of mental health issues including Bi-Polar, auditory issues such as hearing voices, Cognitive problems and a history of psychosis with confusion...Despite multiple efforts by medical staff, adult protective services and myself we were unable to make phone contact with [Spouse F]. [Worker D] relieved me from sitting with [Resident 1] and stated Adult Protective Services would take over.

Shortly after departing the hospital [Worker D] contacted me and informed me they discovered

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N 358	Continued From page 5 [Resident 1] was a patient at Bay View Senior Care located in Sturgeon Bay. [Worker D] informed me they would be launching an investigation as [Resident 1] was just placed as an inpatient there yesterday." On 02/17/2025, Surveyor reviewed the historical weather data for 01/28/2025 for Sturgeon Bay, WI which indicated at 9:30 AM, the weather was approximately 28 degrees Fahrenheit. Source: https://www.wunderground.com/history/daily/us/wi/sturgeon-bay/KSUE/date/2025-1-28. On 02/17/2025, Surveyor reviewed the Wisconsin Department of Transportation, the average daily traffic count near the intersection South 18th Avenue (the road where the facility is located) and state highway 42/57 (necessary to access the facility). The average daily traffic count is 14,200. Source: https://wisdot.maps.arcgis.com/apps/webappviewer/index.html?id=2e12a4f051de4ea9bc865ec6393731f8. On 02/18/2025 at 11:26 AM, Surveyor interviewed Health Unit Coordinator G who confirmed s/he saw Resident 1 walking the halls between 9-9:30 AM. S/he stated s/he asked Resident 1 what s/he was doing and Resident 1 said, "just walking" and s/he went back to his/her room. Health Unit Coordinator G stated, "That was the last I saw of [him/her]. [S/he] walked out the front door. I did not see [him/her] walk out, but I got the alert on the pager. They go off all the time. I went up to check after toileting a resident and did not see anyone." Health Unit Coordinator G reported the front door is not working properly. S/he stated, "It used to be a locked door and you would punch in a code, but now it just opens and closes when you walk in or out."	N 358		

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N 358	Continued From page 6 Surveyor interviewed Caregiver H on 02/14/2025 at 3:42 PM. Caregiver H stated they have issues with their pagers. S/he confirmed they receive alerts on their pagers for resident assistance and the front door every time it opens and closes. Caregiver H reported s/he has an older pager so s/he doesn't get the same alerts compared to the newer pagers. S/he stated s/he gets more lobby alerts versus resident assistance alerts. On 03/05/2025 at 3:39 PM, Surveyor interviewed Resident Assistant Z (RA-Z) who stated it is concerning the facility's front door does not alert the pager who is entering or exiting the facility. RA-Z reported this leaves residents who are elopement risks in possible danger. (Surveyor note: All staff carry a pager for resident call lights and front door entry/exit.) RA-Z expressed, "On days without Office Manager AA (OM-AA) seated at the front desk or AD-A in the office near the front door, the door is not monitored." RA-Z explained further, "To ensure residents are safe I am running to the front door each time the pager indicates 'front door' which is difficult when I am assisting residents with cares." Surveyor interviewed Citizen L on 02/18/2025 at 11:00 AM. Citizen L identified him/herself as the individual who saw Resident 1 in front of Hospital E the morning of 01/28/2025. (Surveyor note: Hospital E is approximately 1.5 blocks away from the facility.) Citizen L recalled it was a cold morning and Resident 1 had a light jacket on, but no hat or gloves. Citizen L stated, "[S/he] stuck [his/her] thumb out like [s/he] was hitchhiking. I stopped and asked [him/her] where [s/he] was going and [s/he] didn't say anything, so I asked [him/her] again. [S/he] then said 'I don't know.'" Citizen L stated, "I also asked [him/her] where	N 358		

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[s/he] lived and [s/he] couldn't tell me. I knew something was wrong, so I brought [him/her] to the police station."

Surveyors interviewed AD A on 02/14/2025 at approximately 8:30 AM. AD D indicated Resident 1 was a respite admission on 01/27/2025 and was going to be staying at the facility for about 2 months. AD A reported Resident 1 was assessed by Nurse J prior to his/her admission and was not identified as an elopement risk. S/he confirmed Resident 1 was on 2-hour safety checks prior to the elopement on 01/28/2025. AD A stated Resident 1 continued to exit seek multiple times while in their care so due to this and not having direct supportive services, "We felt this was not the right place for [him/her]." Surveyors inquired about the alarm system. AD A indicated the building was struck by lightning on 10/30/2024 and this affected the whole building including their phones, internet and alarm on the front door. AD A reported they are working on getting a whole new system, but did not know when it would be fixed. AD A stated every time the front door opens and closes, staff get an alert on their pagers and the expectation is within 5 minutes they physically go to the front door to check. AD A confirmed there have been no other elopements since 10/30/2024 aside from Resident 1.

On 03/12/2025 at approximately 1:00 PM, Surveyors interviewed Regional Director (RD) K who reported the front doors are currently being worked on and should be corrected by Friday (03/14/2025). RD K stated their system was outdated and needed to be updated, so every outside door has to be connected. Surveyor inquired about the facility's document titled, "[Resident 1] January 28, 2025 Elopement" and RD K confirmed this was their facility's internal

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N 358	Continued From page 8 investigation into Resident 1's elopement. RD K reported the information was collected and provided to Compliance Officer X to type up.	N 358		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 2 received adequate and appropriate care within the capacity of the facility. Resident 2's physician ordered a Urinalysis (UA) on 01/13/2025. The UA was not obtained, and Resident 2 was admitted to the Emergency Room (ER) with a significant urinary tract infection. Findings Include:	Y3244		

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Y3244	Continued From page 9 On 02/03/2025, the Department received a complaint the provider was not providing adequate care and supervision. The facility is licensed to provide services for up to 70 residents who may be advanced aged, irreversible dementia/Alzheimer's, physically disabled and/or terminally ill. On 02/17/2025, Surveyor reviewed Resident 2's Individual Service Plan (ISP) dated, 09/30/2024, stated the following information regarding care needs and diagnoses for Resident 2. Diagnoses: " ... Urinary Tract Infection, site not specified, Type II diabetes mellitus without complications and [Genital] atrophy ..." - Toileting: "Follow their toileting schedule and assist in monitoring and assisting ...Continent/Incontinent of bladder - Wears incontinent pads always ... report changes in urinary habits and assist with toileting needs. Report changes in urinary pattern including color, amount, frequency, pain with voiding .... Toileting schedule 12x every day." - Bathing: "Provide partial assistance bathing/showering ... Allow [Resident 2] to wash areas that [s/he] can. Assist with areas [s/he] cannot wash ... Report changes in skin condition. Offer body lotion following showers...Schedule: Monday and Friday at 6:00 PM." - Change Bed Linens: "Change bed linens on the day the resident receives the first shower of the week, and as needed if linens are soiled. Will need a bed pad on [his/her] bed and [his/her] recliner d/t [sic] incontinence. [Resident 2] has [his/her] own sheets (2 sets) and comforter."	Y3244		

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Y3244	Continued From page 10 - Mobility: 'Uses wheelchair as primary and can propel self. Ambulates with staff assist of 1, gait belt, walker, wheelchair following. Report changes in ability to safely ambulate." - Transferring: "Typically transfers [him/herself] but may ask for assistance getting [his/her] legs into bed. [S/he] will call if [s/he] needs assistance with transfers. Staff to use gait belt and walker when assisting with transfer. Resident will call when assistance is needed. Report changes in ability to transfer safely." - Positioning: "Independent - No assistance required with positioning needs." - Fall Risk: "Resident is at risk for falls related to prior history of falls, knee pain/osteoarthritis, diabetes, vision problems." On 02/17/2025, Surveyor reviewed a Physician Communication Form completed by the facility's Licensed Practical Nurse T (LPN-T) on 01/13/2025. The form describes "[Resident 2] has become weaker with increased incontinence and urine has increased odor. UA Request" The form was faxed to Advanced Practice Nurse Practitioner APNP-O requesting "Please order UA" The form was signed by APNP-O on 01/13/2025 and a UA was ordered for Resident 2. On 02/17/2025, Surveyor reviewed the facility's observation note for 01/17/2025, recorded by Life Enrichment X (LE-X). LE-X explained s/he entered Resident 2's room to ask if s/he was coming out for lunch. Resident 2 stated yes but s/he needed help getting out of bed. LE-X told Resident 2 they would be right back to assist them after they let two other residents know it was lunchtime. Short time after Resident 2 was	Y3244		

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calling for help and found on the floor by an outside agency aide.

On 02/17/2025, Surveyor reviewed the facility's observation note for 01/18/2025, recorded by Resident Assistant U (RA-U). Resident 2 complained of pain in his/her left hip and lower back throughout the day. RA-U stated Resident 2 repeatedly said they did not want to be seen by a physician. RA-U stated Resident 2 could not sit up to take medications or eat supper by 4:00 PM without screaming in pain. RA-U called on-call and Family Member N (FM-N) to update them on Resident 2's condition. FM-N advised to call the medics. Resident 2 was transported to Door County Medical Clinic - Emergency Room (DCMC-ER).

On 02/17/2025, Surveyor reviewed Resident 2's DCMC-ER discharge report for 01/18/2025.

Discharge report indicates the following in part ...
"Time seen by provider: 01/18/2025 17:44."
"Chief complaint: Patient reports falling out of [his/her] wheelchair yesterday. Patient complains of lower back pain attempting to get out of bed today."
Resident 2 was given a lumbar x-ray, and findings are negative for any fractures. Resident 2 was discharged back to the facility, medical order to continue the current prescribed medication for pain.

On 02/17/2025, Surveyor reviewed the facility's observation note for 01/20/2025, recorded by Health Unit Coordinator G (HUC-G). HUC-G stated Resident 2 did not eat breakfast, lunch or dinner today. Resident 2 could not sit up in a sitting position or stand. HUC-G stated they changed Resident 2 in bed. HUC-G stated when

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they went to check Resident 2's blood pressure they noticed s/he was "hot to the touch." HUC-G said they took Resident 2's temperature and it was 101.7. HUC-G contacted on-call and was advised to call 911. HUC-G stated Emergency Medical Transport took over care of Resident 2 upon arrival and Resident 2 was transported to DCMC-ER.

On 02/17/2025, Surveyor reviewed Resident 2's DCMC-ER discharge report for 01/20/2025. The documentation revealed Resident 2 was taken to the emergency room again on 01/20/2025 for weakness and inability to obtain a UA.

Discharge report indicates the following in part ... "Time seen by provider: 01/20/2025 18:50." "Chief Complaint: Per report, patient sent to [emergency room] for weakness and [her/his] nursing home unable to collect UA sample."

Additionally, the report describes, in part, " .... presenting via [emergency medical services] after the assisted living facility noted that [s/he] had a fever of 100.9 today. The assisted living facility also notes [s/he] has worsening confusion and worsening ability to ambulate over the past week, apparently, they had a urine analysis order placed that was unfortunately never performed ..." The report indicates abnormal test results, Urine Is consistent with a urinary tract infection. Resident 2 prescribed Cephalexin (Antibiotic medication used to treat a wide variety of bacterial infections) 500 mg capsule every 12 hours.

Additional note included on discharge summary, written as "ER Nursing Note by [RN-Q]" states in part, " ...Patient arrived via [emergency medical services] from [provider] covered in urine from head to toe. [Her/his] pajama dress was also

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soaked with urine, and very foul smelling. When completing the skin assessment, patient is showing signs of skin breakdown on whole right side of body and back, [her/his] skin was Indented [sic] from Immobility [sic]. [RN-Q] completed bed bath and put patient In [sic] clean gown and changed brief. When cleaning [her/his] perineal area, there was dried stool In [sic] [her/his] groin areas. Upon obtaining a urine sample via straight cath [sic], [her/his] urine appeared very cloudy and had white pus ...."

On 02/18/2025, Surveyor interviewed Family Member V (FM-V) on the phone. FM-V explained after Resident 2 was transported to DCMC-ER on 01/20/2025, FM-N requested FM-V to pick up Resident 2's cellphone from Resident 2's room at the facility. FM-V stated upon entering Resident 2's room FM-V observed Resident 2's bedding soiled and described it smelling foul like urine and feces. FM-V said s/he found gloves and removed the bedding from Resident 2's bed and cleaned the mattress cover. FM-V stated there were no clean sheets available to make the bed therefore s/he had to purchase a new set of sheets to make the bed.

On 02/18/2025, Surveyor reviewed documentation dated 01/21/2025, recorded by Managed Care Organization Care Manager R (MCOCM-R). MCOCM-R indicated they returned a call to FM-N. FM-N provided an update, indicating Resident 2 fell on 01/17/2025 and was transported to DCMC-ER on 01/18/2025 and 01/20/2025.
FM-N stated Resident 2 is not doing well and after FM-N spoke to the hospital regarding Resident 2 they will be referring Resident 2 for hospice services. FM-N expressed s/he has a long list of concerns/issues to discuss about the

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facility and requested a meeting with them. MCOCM-R arranged a meeting with facility for 01/30/2025.

On 02/18/2025, Surveyor reviewed documentation dated 01/29/2025, recorded by MCOCM-R, indicating they were made aware of admission notes from DCMC-ER staff when Resident 2 went to DCMC-ER on 01/20/2025. MCOCM-R reported concerns of neglect to Door County Adult Protective Services (DC APS) on 01/29/2025, who plan to investigate. MCOCM-R noted facility Registered Nurse J (RN-J) asked MCOCM-R to elaborate as to why Adult Protective Services (APS) was involved. MCOCM-R wrote, in part, " .... [MCOCM-R] was provided an update, [interdisciplinary team] (IDT) received communication from [Door County Medical Clinic] regarding the condition [Resident 2] arrived in when [s/he] was sent to the hospital on 1/20. This was reported to APS due to concerns of neglect."

On 02/18/2025, Surveyor reviewed documentation dated 01/31/2025, recorded by Managed Care Organization Care Manger Registered Nurse (MCOCMRN-S) from a meeting with following individuals including MCOCMRN-S:

- Advanced Practice Nurse Prescriber (APNP-P)
- Director of Nursing J (DON-J)
- Regional Director K (RD-K)
- Assistant Director A (AD-A)
- Health Unit Coordinator G (HUC-G)
- FM-N
- Adult Protective Services (APS-D)
- MCOCM-R

MCOCM-R reviewed the DCMC-ER report which detailed Resident 2's condition upon admission to

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the ER on 01/20/2025. MCOCM-R explained Resident 2's condition described by DCMC-ER indicated alleged neglect and was reported to APS-D.
MCOCM-R discussed concerns regarding the physician's order for UA not collected/completed and no notification to the physician. MCOCM-R reminded facility staff they must ensure orders are followed through and orders and/or requests are sent to provider APNP-P and not to APNP-O. MCOCMRN-S reminded facility staff of the contractual agreement to update IDT for any resident falls.

On 03/10/2025, Surveyor received an email from RD-K on 02/19/2025. The document attached to the email was titled "UA Documentation Combined". The document revealed unsuccessful attempts to obtain a UA since ordered on 01/13/2025. The document itself was not dated or signed but RD-K confirmed creating it after talking with staff.

The document titled, "UA Documentation Combined" includes the following information:

"A fax was received signed by [APNP-O] on 1/13/2025 - to get a UA order."

"Upon receipt, the LPN informed staff so they could attempt to get a clean urine sample."

"Staff continued to attempt collection."

"Resident sent to [ER] on 1/18 and noted to [EMS] that they have been unsuccessful with collection."

"Resident returned to [Facility], with no new concerns noted. While at [Door County Medical

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Clinic] a urine sample was not collected to check for a UTI."

"Resident returned to [Emergency Room] on [1/20], when [Door County Medical Clinic] was successful in collection and testing of the sample."

"January 14th,2025 [sic]- 10a.m. [sic] [HUC-G] attempted to get a UA on resident. [S/he] had a [BM] also it was contaminated. HUC-G"

"January 15th, 2025 - "[RA-U] tried collecting a urine sample from resident each time writer tries taking [him/her] to the bathroom. When assisting resident to the bathroom, resident had already went [sic] in [his/her] brief, or resident had a BM [sic] accident. When [s/he] was on the toilet, [s/he] would state [s/he] did not need to go even after sitting a while. Resident did urinate in the [hat] but then had a loose BM in the [hat]. [S/he] also would say [s/he] did not want to get up due to back pain. [RA-U]"

"January 16th, 2025- [RA-U] tried collecting a urine sample [sic] but resident would say [s/he] already took [himself/herself] and refused to go again. Resident would have already went [sic] in her brief and would not go when sitting on the toilet. Resident stated [s/he] did not want to get up and try due to not feeling well from the back pain and a headache. [RA-U]"

"January 17th, 2025- Resident was complaining of back pain and refusing to get up out of bed. [RA-U] encouraged [him/her] to get up to use the bathroom but [s/he] did not want [RA-U] to touch [him/her]. [S/he] stated that [s/he] couldn't get up to use the bathroom from not feeling well. Attempted but resident did not need to go as

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Y3244	Continued From page 17 [s/he] urinated all over the floor. [RA-U]" "On 1/17/2025, [LPN-T] and staff member attempted to collect a urine sample from the resident, it took 2 staff to pivot transfer resident to wheelchair and was [sic] 2 staff to assist resident on toilet. Resident had an incontinent accident/bowel movement so [LPN-T] and staff member cleaned resident right before transfer to the toilet to increase chances of collecting a usable sample. Resident stated "I can't go" [LPN-T] and staff member tried giving [him/her] time on the toilet with running water to help. Resident was only able to produce a few drops of urine, not enough for a UA. [LPN-T] "January 18th, 2025- Resident would not get out of bed. [S/he] was complaining of back pain and left hip pain. When trying to touch [him/her], [s/he] would yell out in pain. Sent [him/her] to the hospital, did explain to them that [s/he] had a UA order and could not get due to it being contaminated. [RA-U]" "January 18th,2025 [sic]- 10am [sic] HUC-G attempted to get UA. Resident could not stand or pivot transfer to get a UA. Resident was changed in bed. Noon- [HUC-G] attempted again to try to get UA. Resident was to weak to stand or pivot transfer. Resident was changed in bed. 2:30pm- [HUC-G] and another staff went into residents [sic] room changed resident in bed. 4:00pm- [HUC-G] went in to [sic] residents [sic] room and resident said I'm to [sic] weak to try to go to the bathroom. [HUC-G] changed resident in bed. 5:30pm- [HUC-G] went in to [sic] residents [sic] room to get vitals and noticed [s/he] was warm. [HUC-G] went and got a thermometer. Writer took residents [sic] [temp] it was 101.7. [HUC-G] called [Executive Director] which contacted the	Y3244		

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nurse and they told [HUC-G] to contact 911. [HUC-G] and other staff member changed resident and night gown and [Emergency Medical Technicians] came and took over cares. Resident was then transported [Door County Medical Clinic]. [HUC-G]"

"January 19th, 2025- Changed in bed due to pain. [RA-U]"

Further review of Resident 2's observation notes revealed no evidence the UA was collected, or the physician was notified for six days.

The National Library of Medicine stated the following regarding UTIs:

"Urinary tract infection (UTI) is a common infection ...mainly due to ...related risk factors like malnutrition, inadequately controlled diabetes mellitus, poor bladder control leading to urinary retention or incontinence, constipation, long-term hospitalizations, vaginal atrophy, prostate hyperplasia, unhygienic living conditions, and altered mental state ..."
"UTI usually presents with localized symptoms like painful urination, new onset or worsening urinary urgency or frequency, and suprapubic pain... UTI manifests more atypically ... as delirium, confusion, dizziness, drowsiness, falls, urinary incontinence, or poor appetite in the absence of fever making the diagnosis of UTI a difficult task ..."
Information obtained on 03/20/2025 at 9:05AM at: https://pmc.ncbi.nlm.nih.gov/articles/PMC9827929/

Review of Resident 2's notes showed an increase in UTI symptoms as noted in the information obtained from the National Library of Medicine.

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Y3244	Continued From page 19 On 01/17/2025, Resident 2 experienced a fall. Information from the UA Documentation provided to the Surveyor on 03/10/2025, noted the following: -01/16/2025: Resident 2 was not feeling well and complained of backpain and headache. -01/17/2025: Resident 2 was feeling weak and did not want to be touched. -01/18/2025: Resident 2 was feeling weak and was changed in bed at 10:00AM, 12:00PM, 2:30PM and 4:00PM. Resident 2's ISP identified s/he has a diagnosis of diabetes mellitus, [genital] atrophy and a history of UTI, which increases a person's risk for experiencing a UTI. Resident 2's ISP also noted: changes in skin condition should be reported changes in urinary patterns including color, amount, frequency, and pain when voiding should be reported. Additionally, the DCMC-ER discharge report documented Resident 2's was covered "from head to toe" in urine and his/her pajamas were soaked with foul smelling urine. Resident 2 had skin breakdown and indentions from immobility. Additionally, the UA sample had to be obtained with a catheter. The urine was cloudy and contained pus. The sample resulted in a positive identification of a UTI. On 03/10/2025, Surveyor received an email from RD-K. RD-K provided documentation of the facility's investigation regarding cares and cleanliness of Resident 2, but it did not address the delay of obtaining a UA sample. RD-K provided no further information at the time of the exit on 03/12/2025, at approximately 1:30 PM.	Y3244		

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Y3244	Continued From page 20 Due to the delay of obtaining a UA sample and communicating with APNP-O, Resident 2 experienced multiple symptoms and was diagnosed with a UTI.	Y3244		