| 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 _____ | R-C 08/13/2025 |

| 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<br><br>On 07/30/2025, with additional information gathered through 08/13/2025, Surveyors conducted a verification visit and 5 complaint investigations at Bayview Senior Care LLC.<br><br>Two of 2 previous deficiencies were corrected. Three of 5 complaints were substantiated. Two complaints were unsubstantiated. Four deficiencies were identified.<br><br>One deficiency was a repeat violation, see Statement of Deficiency (SOD) I6MI11, dated 02/27/2024.<br><br>Under statutory provisions of WI Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 50 | {N 000} | | |
| N 396 | 83.36(1)(a) Adequate staff to meet resident needs.<br><br>The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the provider did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents.<br><br>At the time of survey, 50 residents were residing at the facility and receiving services. At least 29 shifts from May - July 2025 had only 2 care staff providing services to all residents during awake hours.<br>Of these 50 residents:<br>At least 9 residents were considered enhanced | N 396 | | |

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

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| N 396 | Continued From page 1 | N 396 | | |

care and required additional supervision and assistance and resided on the enhanced care wing.
At least 6 residents were identified as requiring additional supervision or assistance (wanderguard bracelet, care needs, 2-staff assist, supervision, etc.), but did not have a room on the enhanced care wing.
At least 6 residents were identified as exit seeking and wore a wanderguard bracelet.
At least 5 residents were identified as requiring a Hoyer mechanical lift for transfers.
At least 4 residents were identified as requiring assistance from 2- staff.
At least 3 residents were identified as requiring a Sit-to-stand mechanical lift for transfers.
At least 2 residents were identified as taking longer than 4 minutes to evacuate safely in the case of an emergency and required point-of-rescue.

Findings include:

The provider is licensed as a Class CNA (non-ambulatory) community-based residential facility to provide services for up to 70 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia.

On 03/12/2025, 03/26/2025, and 04/02/2025, the department received complaint information alleging an inadequate number of staff to meet resident needs.

On 07/30/2025, Surveyors conduct a complaint investigation.

On 07/30/2025 from approximately 9:30 AM until 2:30 PM, Surveyors were onsite at the facility.

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| N 396 | Continued From page 2<br><br>Surveyor reviewed the facility floor plan in reference to observations and noted the facility was a large rectangular building. As you walk in the main doors, you see a common area with a reception desk and 2 offices to the right before you cross the front open hallway into another 2 open common areas and the dining room. On each side of the common areas from the entrance were a movie room and library to the right, and chapel and sunroom to the left, as well as an outdoor courtyard on either side. As you cross the back open hallway is a large kitchen. A hallway with 66 resident rooms surrounded the perimeter of the building with a small dining room/common area on each corner.<br>The front doors were 2 sets of sliding doors that automatically opened upon movement towards them. Each hallway was separated by fire doors; none of the internal doors were closed or delayed egress. The wanderguard system was set up to alarm when a resident wearing a wanderguard was near or through the exit doors. When the door alarms would sound, all staff were to attend to the alarming door. The alarming exit door is identified strictly by sound. The provider identified the wing of resident rooms to the first right of the entrance as the "enhanced care" side.<br><br>On 07/31/2025 at approximately 11:15 AM Surveyor reviewed written correspondence from Regional Director (RD) K who listed 6 residents who wore wanderguard bracelets - Resident 2, Resident 3, Resident 14, Resident 16, Resident 23, and Resident 24. S/he listed 5 residents who required a Hoyer mechanical lift for transfers -Resident 3, Resident 4, Resident 17, Resident 18, and Resident 19, and 3 residents who required a sit-to-stand mechanical lift - Resident 20, Resident 21, and Resident 22. | N 396 | | |

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| N 396 | Continued From page 3<br><br>On 08/04/2025 at approximately 11:27 AM, Surveyor interviewed Director of Nursing (DON) J. DON J noted the facility had 47 current residents in the facility. Surveyor inquired how many residents were considered or lived on the enhanced care side and DON J said around 9 or possibly 10. Surveyor inquired how many residents had wanderguard bracelets and/or were identified as exit seeking. DON J listed 6 residents - Resident 3, Resident 4, Resident 14, Resident 16, Resident 23, and Resident 24. Surveyor inquired what residents required 2-staff assistance and DON J named 4 residents - Resident 2, Resident 4, Resident 17, and Resident 18. DON J stated if a resident were to need more assistance, "they would be moved to a room on the enhanced care side ...so we can keep on eye on them." Surveyor inquired whether there were any residents who didn't live on the enhanced care side that they had to check on more than others and DON J stated "[Resident 15] gets extra checks."<br><br>Surveyor note: Resident 15, Resident 16, Resident 18, Resident 19, Resident 23, and Resident 24 did not have rooms located in the enhanced care wing.<br><br>DON J described the enhanced care side as "typically having an attendant" who was there for extra assistance to help with meals, doing activities with the residents on that wing, and walking through the unit and checking on residents. Surveyor inquired how often an attendant was scheduled and s/he said they try for 8:00 AM - 2:00 PM or 4:00 PM, and then another one from 2:00 PM or 4:00 PM until 8:00 PM or 9:00 PM. DON J said that they do not always have an attendant. DON J said the attendant does not do personal cares, toileting, or | N 396 | | |

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assist with transfers, they were specifically there for the common area of the wing. DON J stated there was usually a caregiver down the wing as well.

Surveyor inquired about the facility's usual staffing schedule. DON J said their goal was to have a caregiver, medication passer, and attendant for the memory care side, and a caregiver and medication passer for the other side and wings on AM's and PM's. DON J said Administrative Coordinator (AC) C often came in at 6:00 AM to do the morning medication pass and then was responsible to complete his/her other assigned duties off the floor. DON J indicated the staffing schedule was a collaborative effort, and was completed by him/her, Assistant Director A, RD K, and AC C.

On 07/30/2025 at 11:26 AM, Surveyor interviewed AC C who stated s/he worked in the office and also on the floor with resident cares. S/he reported, "Staffing hasn't been the greatest. There are 2 staff on each shift, a medication passer and a resident assistant. I don't feel that is enough staff to get things done. It's a lot. Management tries to help when they can."

On 08/04/2025 at 11:14 AM, Surveyor interviewed Health Unit Coordinator (HUC) G who reported s/he works in the office and helps with physician orders and faxes, but s/he also works the floor and assists with resident cares. S/he stated, "It's hard to get everything done."

On 07/30/2025 at approximately 11:15 AM, Surveyor interviewed Dietary Coordinator P. Surveyor inquired how staffing was and Dietary Coordinator P stated "we're trying." Dietary Coordinator P stated s/he worked in the kitchen

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primarily, but did have to help on the floor as a caregiver as well due to short staffing.

On 08/04/2025 at approximately 12:10 PM, Surveyor received written correspondence from RD K that verified 4 residents who required 2-staff assistance - Resident 2, Resident 4, Resident 17, and Resident 18.

On 07/30/2025, Surveyor reviewed the provider's "Wanderguard Policy & Procedure" and noted "When a resident with a Wanderguard passes through the front door or any of the egress doors throughout the building, an alarm will be sent to the staff pagers ...when staff get a notification via their pager, ALL STAFF will respond ...Staff are to watch all outlying doors and redirect any residents who are wandering in the area of the doors."

RECORD REVIEWS
On 07/31/2025, Surveyor reviewed Resident 2, Resident 3, Resident 4, Resident 11, Resident 12, Resident 14, and Resident 15 sample most recent individualized service plans (ISP) with print dates of 07/30/2025.

Resident 2 had diagnoses of protein-calorie malnutrition and osteoarthritis. S/he required 24/7 supervision, required 2-staff assistance and transferred with a Hoyer mechanical lift. Resident 2 required full assistance with all activities of daily living (ADL's), had a foley catheter, and was on hospice services.

Resident 3 had diagnoses of Alzheimer's disease, arthritis, and congestive heart failure. S/he required 24/7 supervision, assistance making his/her needs known, full assistance with toileting, bathing, dressing, housekeeping and laundry,

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redirection and monitoring, medication administration, and 30-minute safety checks.

Resident 4 had diagnoses of vascular dementia, senile degeneration of the brain, anxiety, attention deficit disorder, and recurrent falls. Resident 4 required 24/7 supervision, full assistance with all ADL's, 2-staff assistance, medication administration, mechanical lift transfers, and making his/her needs known. Resident 4 was identified as taking longer than 4 minutes to safely evacuate from the facility in the case of an emergency and was a point-of- rescue.

Resident 11 required 24/7 supervision, assistance with toileting, bathing, dressing, medication administration, housekeeping and laundry, emotional support, redirection, and 2-hour safety checks.

Resident 12 had diagnoses of Alzheimer's disease, type 2 diabetes, obstructive sleep apnea, and heart failure. S/he required full assistance daily with upkeep of his/her room and laundry, medication administration, and was on 2-hour safety checks.

Resident 14 had diagnoses of dementia and chronic pain. S/he required 24/7 supervision, full assistance with bathing, dressing, laundry and housekeeping, medication administration, weekly weights, redirection and monitoring, and 30-minute safety checks.

Resident 15 had diagnoses of heart disease, unsteadiness on feet, and right lower left leg wound. S/he required 24/7 supervision, full assistance with bathing, dressing, laundry and housekeeping, transferring, medication administration, cues with eating, toileting,

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mobility, weekly weights, fall risk, and 2-hour safety checks. Resident 15 was identified as taking more than 4 minutes to evacuate and was a point-of-rescue.

On 07/30/2025 at approximately 10:00 AM, Surveyor interviewed Resident 12. Resident 12 stated the facility was very short staffed and his/her bed wasn't always made. Resident 12 indicated s/he spent quite a bit of time with Resident 11. S/he said s/he felt that staff depended on him/her to assist Resident 11. Resident 11 stated "this is not how it [staffing] should be." Resident 11 stated "I hardly feel safe [here]." Resident 12 shook his/her head in agreement and said "sometimes I feel the same way because of [low] staffing." Resident 12 indicated s/he was worried about some staff going back to school in the Fall and how that would impact the staffing.

On 08/13/2025 at approximately 11:14 AM, Surveyor interviewed Power of Attorney for Healthcare (POAHC) M. POAHC M indicated s/he visited Resident 12 at the facility fairly often. S/he voiced concerns about the facility being "very understaffed" and that s/he rarely saw staff when s/he was there visiting. S/he stated that Resident 12 does have some incontinence troubles and so will need his/her bedding changed. POAHC M indicated on more than one occasion, s/he has gone to the facility and has had to change and make Resident 12's bed because staff had not gotten to it because they were understaffed. POAHC M said Resident 12 has slept in his/her chair before because of his/her bed not being changed and made.

On 08/07/2025 at approximately 10:13 AM, Surveyor interviewed POAHC O who reported

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feeling there were not enough staff to meet resident needs, especially on weekends. POAHC O indicated Resident 3 required assistance with activities of daily living (ADL's), supervision with wandering and redirection, and Resident 4 required 2-staff assistance with transferring in a Hoyer lift, and full assistance for all ADL's.

On 08/05/2025 at approximately 8:15 AM, Surveyor interviewed Ombudsman N who stated s/he always had a hard time locating staff during his/her various visits. S/he stated from his/her assessment there were not enough staff to meet all of the resident needs. Ombudsman N stated the facility was very large and spread out, making it an extra challenge if the 2 staff scheduled at a given time were in a wing located on the other side of the building as the enhanced care wing to provide appropriate supervision.

On 08/05/2025, Surveyor reviewed May - July 2025 sample staff schedules. There were at least 29 shifts where there were only 2 staff working the floor as care staff. No attendants were scheduled on these days.
05/21/2025 6:00 AM - 2:00 PM
05/23/2025 6:00 AM - 2:00 PM
05/24/2025 6:00 AM - 2:00 PM
05/25/2025 6:00 AM - 2:00 PM
05/26/2025 6:00 AM - 12:00 PM
05/27/2025 6:00 AM - 2:00 PM
05/27/2025 2:00 PM - 10:00 PM
05/28/2025 6:00 AM - 2:00 PM
05/28/2025 2:00 PM - 4:00 PM
05/29/2025 6:00 AM - 10:00 AM
05/29/2025 2:00 PM - 10:00 PM
05/30/2025 6:00 AM - 2:00 PM
05/30/2025 2:00 PM - 4:00 PM
05/31/2025 6:00 AM - 8:00 AM
05/31/2025 5:00 PM - 10:00 PM

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06/04/2025 6:00 AM - 2:00 PM
06/04/2025 2:00 PM - 10:00 PM
06/08/2025 6:00 AM - 2:00 PM
06/12/2025 6:00 AM - 8:00 AM
06/28/2025 10:00 AM - 2:00 PM
06/29/2025 10:00 AM - 2:00 PM
07/03/2025 11:00 AM - 2:00 PM
07/04/2025 6:00 AM - 8:00 AM
07/05/2025 6:00 AM - 10:00 AM
07/06/2025 6:00 AM - 10:00 AM
07/26/2025 6:00 AM - 2:00 PM
07/26/2025 2:00 PM - 10:00 PM
07/27/2025 6:00 AM - 2:00 PM
07/27/2025 2:00 PM - 10:00 PM

In conclusion, of the 50 residents, there were residents who: required use of a mechanical lift, required assistance from 2 staff at a time, required assistance with ADL's, were on 30-minute, were on 2-hours checks, required extra supervision due to wandering, were exit seeking, and/or took longer than 4 minutes to evacuate. 2 caregiving staff during awake hours was not sufficient in meeting 50 residents' needs.

On 08/06/2025 at approximately 10:00 AM, Surveyors interviewed DON J and RD K. Surveyor stated there were a number of days where there were only 2 staff on the schedule for all of the residents and RD K stated yes. RD K acknowledged inadequate staffing and stated "it's just a struggle ...we are always looking and always having staff being hired." RD K stated they cross-trained with sister facilities when they can, but that can be challenging too.

Cross Reference:
N0426 83.38(1)(b) Supervision
N0431 83.38(1)(g) Health Monitoring
N0489 83.44(2)(a) Rooms Clean and Free From

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| N 426 | 83.38(1)(b) Supervision.<br><br>As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the provider did not provide supervision appropriate to meet the resident's needs. Resident 11 was observed to wander the facility searching for someone or a room and would go into other resident rooms. Resident 3 and Resident 14 were identified as entering other resident rooms often, looking for their own rooms. Multiple residents left their doors closed and/or locked due to residents entering their rooms without permission. Resident 13 had a mesh guard on his/her door to deter others from his/her door.<br><br>Findings include:<br><br>The provider is licensed as a Class CNA (non-ambulatory) community-based residential facility to provide services for up to 70 residents who may be physically disabled, of advanced | N 426 | | |

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age, terminally ill, and/or have Alzheimer's/dementia.

On 03/12/2025, 03/26/2025, and 04/02/2025, the department received complaint information alleging concerns with resident supervision and residents wandering.

On 07/30/2025, Surveyors conducted a complaint investigation and verification visit for Statement of Deficiency F32B11, dated 03/12/2025 which referenced concerns with resident supervision and an incident of elopement. In correction, the provider installed a Wanderguard system.

On 07/30/2025 from approximately 9:30 AM until 2:30 PM, Surveyors were onsite at the facility. Surveyor reviewed the facility floor plan in reference to observations and noted the facility was a large rectangular building. As you walk in the main doors, you see a common area with a reception desk and 2 offices to the right before you cross the front open hallway into another 2 open common areas and the dining room. On each side of the common areas from the entrance were a movie room and library to the right, and chapel and sunroom to the left, as well as an outdoor courtyard on either side. As you cross the back open hallway is a large kitchen. A hallway with 66 resident rooms surrounded the perimeter of the building with a small dining room/common area on each corner.
The front doors were 2 sets of sliding doors that automatically opened upon movement towards them. Each hallway was separated by fire doors; none of the internal doors were closed or delayed egress. The wanderguard system was set up to alarm when a resident wearing a wanderguard was near or through the exit doors. When the door alarms would sound, all staff were to attend

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to the alarming door. The alarming exit door is identified strictly by sound. The provider identified the wing of resident rooms to the first right of the entrance as the "enhanced care" side.

On 07/30/2025 at approximately 9:40 AM, Surveyors walked into the facility and noted the front door of the facility were 2 sets of automatic sliding doors that would automatically slide open when near them. Surveyor noted a sign on the inside of the sliding doors that said Caution Do Not Open Door for Residents. While reading the sign, the doors automatically slid open.

On 08/04/2025 at approximately 11:27 AM, Surveyor interviewed Director of Nursing (DON) J. Surveyor inquired about the residents who lived on "Wing 1," which DON J described as being the "enhanced care" side as if a resident were to need supervision then s/he would be living on that side. S/he said there were around 9, possibly 10 residents that s/he would identify as enhanced care. Resident 3, Resident 11, and Resident 14 resided on the enhanced care wing.

RESIDENT 11
On 07/30/2025, Surveyor reviewed Resident 11's record and noted s/he was admitted to the facility on 08/12/2024 with an activated Power of Attorney for Healthcare (POAHC). No diagnoses were listed in Resident 11's record provided to Surveyor.
Resident 11's facility face sheet listed "Key Indicators ...Wander Risk"

Surveyor reviewed Resident 11's individualized service plan (ISP) dated 04/15/2025 and noted s/he required 24-hour supervision.

Resident 11's record showed evidence of

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| N 426 | Continued From page 13<br>Resident 11 requiring verbal cues, reminders, physical guidance and redirection. Surveyor noted his/her ISP listed:<br>"DRESSING - ASSIST ...Requires monitoring and assistance as needed with dressing and undressing as well as choosing proper attire. Resident does not like to be cold and will layer several items."<br>"EATING - INDEPENDENT ...NEEDS REMINDERS IT IS MEAL TIME ...Overall appetite is Fair to Poor- Resident likes to "hide [his/her] candy" Likes Pepsi and Cookies, Peanut Butter, Cookies, Ice Cream, etc [sic] Will often TELL YOU I'M NOT HUNGRY BUT WILL STILL EAT IF YOU PUT IT IN FRONT OF [HIM/HER]. Report changes in meal intake or weights."<br>"SLEEP QUALITY AT NIGHT ...Directions: Document quality of sleep each night Usually will not sleep in [his/her] bed - but will sleep on [his/her] couch Does get up to use the bathroom at night."<br>"WANDERING/ELOPEMENT RISK - STAFF MONITOR REQUIRED (Behavior Patterns/Wandering Risk) Directions: Provide supervision and redirection to avoid and prevent wandering episodes. If wandering occurs, determine follow-up plan. "Know [his/her] _whereabouts - redirect as needed. *Always have a family or staff member with them outside *Take note of his/her _ clothing daily to be able to describe him/her _ in the event of an elopement Resident typically goes through out [sic] the building looking for [his/her] friend- Family- POA do [sic] not want Resident to have a wander guard bracelet at this time as [s/he] has made no attempts to leave the building ...Resident's Desired Measurable Goals & Outcomes: To maintain low level of wandering episodes."<br>"DEPRESSION* (Behaviors Patterns/Other Behavior: ) Current Status: Resident does not | N 426 | | |

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show signs of depression. But may have times where [s/he] is tearful Resident [sic] does have a history of depression. Resident shows signs of depression via crying, withdrawal, loss of interest, not eating. Reassure Resident - Update MD."
"ROUTINE 2 HOUR SAFETY CHECK (Physical Health/Safety) Directions: Routine every 2 hour safety checks when in the facility ...Resident's Desired Measurable Goals & Outcomes: Resident will state [s/he] feels safe at the facility by next review."
"COMMUNICATION - ENCOURAGE/INTERVENE (Independent Living Skills/Communication Skills) Directions: To receive encouragement/assistance communicating needs or ideas as they are unable to make these needs known. A&O [alert and oriented] x to self. Accepting of assist [sic] provided by staff Able to understand and follow simple directions."

At approximately 9:45 AM, Surveyors were standing in the common area in front right wing resident hallway located to the right of the main entrance identified as the memory care wing or enhance care wing. Surveyors observed a resident identified as Resident 11 open a room in the hallway labeled as the hair salon. Resident 11 appeared confused and searching for something. Surveyors observed DON J redirect Resident 11 out of the hair salon. Resident 11 indicated s/he was looking to get his/her nails done. DON J pointed down the resident hallway to the left of the entrance, on the other side of the common area, indicating to Resident 11 s/he had to go over to the life enrichment room to have his/her nails done.

Resident 11 then walked past Surveyors towards the dining room, located between the right and

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left resident hallways. Surveyor followed Resident 11 and introduced him/herself and asked if s/he could follow him/her around. Resident 11 said yes. At approximately 9:47 AM, Surveyor observed Resident 11 walk down the left back resident room hallway. Resident 11 said s/he was looking for [him/her]. Surveyor inquired who s/he was looking for and Resident 11 could not say. Surveyor observed Resident 11 check the door handle of resident room 12, but did not open it. S/he then walked into the visitor bathroom, squirted hand soap into his/her hand and smelled it. Resident 11 said "this isn't who I'm looking for" and wiped the hand soap on the wall while greeting and smiling at Surveyor again. Resident 11 continued to walk along the left back hallway and attempted to open room 4, room 5, and room 6 but they were locked. S/he opened room 7's door and peeked in and then closed the door. S/he then checked room 9 and room 8 and the doors were locked. Surveyor inquired who Resident 11 was looking for and s/he said "I can't think of their name." Surveyor did not observe any staff while Surveyor and Resident 11 were in the hallway.
Surveyor asked if s/he knew where his/her room was. Resident 11 said s/he believed so. Resident 11 guided Surveyor to the right front hallway, Wing 1. S/he went to the hair salon door and opened it and looked inside. Surveyor observed Resident 11 then continue down the hallway and stopping in front of Resident 3's door and reading the name. Resident 11 continued to the next room and saw his/her handwritten and said "here it is." Resident 11 attempted to get into his/her door and was unable to as it was locked. Resident 11 grabbed the key on the lanyard around his/her neck and attempted to unlock the door. S/he said s/he was advised to keep his/her door locked but couldn't remember who told

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him/her that. Resident 11 shuffled with the key and was unable to put the key in the keyhole. Resident 11 asked if Surveyor could help him/her as s/he could not unlock the door. Surveyor assisted in unlocking the door with Resident 11's key and followed him/her into his/her room. At approximately 9:57 AM, Surveyor observed Resident 12 to be in Resident 11's room. Resident 11 and Resident 12 welcomed conversation.

Surveyor note: Resident 12 presented alert, of sound mind, oriented, and comprehensive. Resident 12 was able to share both his/her own, as well as Resident 11's history based on what s/he said was shared with him/her by Resident 11 and Resident 11's family members.

Surveyor was with Resident 11 and Resident 12 from approximately 9:57 AM to 10:47 AM. Resident 12 asked Resident 11 whether s/he got his/her nails painted and noted s/he did not. S/he asked "were you not able to find the activity room?" Resident 11 stated "they weren't in the salon." Resident 12 described him/herself as a good friend to Resident 11 and someone who "keeps an eye on [him/her]." S/he said Resident 11 at times thinks s/he was a former partner. Surveyor inquired whether Resident 11 and Resident 12 spent time together daily and Resident 12 stated yes, at times s/he even slept in Resident 11's room with him/her. Resident 12 said anytime s/he was not with Resident 11, s/he was looking for him/her as Resident 11 has been known to have difficulty sleeping and will sometimes sleep in the common areas. Resident 12 indicated s/he lived in on the left front wing. Surveyor note: Resident 11 was in the left back wing earlier during Surveyor observation.

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| N 426 | Continued From page 17<br><br>While conversing, Surveyor observed Resident 11 to make random statements not related to the topic Resident 12 was speaking about, such as "[s/he] must be asleep." Resident 12 questioned who Resident 11 was talking about and Resident 11 would reference "that [wo/man] that always comes in ...I'm afraid of [him/her]." Surveyor noted Resident 11 kept his/her door cracked open approximately 2 inches, enough to be able to see people walking past his/her room. Resident 11 kept checking the door both visually and physically during the conversation to see if anyone was at the door, about to come in, and who was in the hallway. Surveyor observed Resident 11 presented in mild distress and had furrowed eyebrows when s/he thought heard someone talking in the hallway or thought someone was coming in. S/he said "other people come in here often." Resident 11 could not speak to who but said "those 2 [wo/men] are always coming in here, especially that 1." Resident 12 said s/he witnessed residents frequently wandering the halls and into others' rooms, including Resident 11's. S/he identified Resident 3 and Resident 14. Resident 12 said they get confused where their room is and they were Resident 11's neighbors on either side. S/he said Resident 11 was a bit of an antagonist and didn't like Resident 3 and Resident 14. S/he said "but of course [Resident 11] has a tendency to go into others' rooms too." Resident 11 stated there was a [wo/man] who once came in while s/he was on the toilet in the bathroom. S/he said they came in and just stood in the bathroom with him/her and made Resident 11 feel very uncomfortable. Resident 12 said s/he told Resident 11 to keep his/her door locked to keep others out. "We [Resident 12 and Resident 11] have a procedure that we keep our doors locked at all times and put the small table in front of the door, so others don't | N 426 | | |

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come in in the middle of the night." Resident 12 stated his/her room was on the other side of the building and Resident 11's room was in what the provider calls "the memory wing." Resident 12 stated the provider does not provide any special services for living down this wing. S/he said there have been multiple incidents s/he had heard about and observed residents "wandering out" the automatic sliding doors. S/he voiced concern as "the wanderguards set the alarms for the door off, but just set an alarm off and don't actually keep [the residents] safe." S/he said the Wanderguard does nothing for residents going into other resident rooms. Resident 12 said Resident 3 and Resident 14 had wanderguards that set the door alarm off regularly. Surveyor noted Resident 11 and Resident 12 did not have wanderguards and Resident 12 said s/he did not need one and although s/he felt Resident 11 was exit-seeking, s/he did not have one either because s/he wouldn't actually leave when s/he goes by the doors. Resident 12 stated s/he asks to go home frequently. Resident 11 became tearful and asked Surveyor "can you help me get out of here."

At approximately 10:48 AM, Resident 11 asked Surveyor if s/he wanted a tour of the building. Resident 12 said "go get your nails done like you wanted" to Resident 11. Resident 11 guided Surveyor out of the room and to the right towards a small dining room where residents from the enhanced care wing were to eat. Resident 11 said s/he would not eat in this dining room because s/he didn't feel comfortable around Resident 14. Surveyor asked Resident 11 where s/he ate and Resident 11 guided Surveyor to the main common area and pointed to the dining room. Surveyor asked whether Resident 11 was going to get his/her nails done and s/he said "yes,

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but I don't know where." Resident 11 started walking down the left front hallway where the life enrichment room was located. Resident 11 went to the doorway and spoke with Life Enrichment Coordinator (LEC) E who scheduled a nail appointment with Resident 11 as s/he was setting up for a new activity. LEC E invited Resident 11 in for the music activity, however Resident 11 declined. Resident 11 and Surveyor looked in the life enrichment room through the large glass window spanning the length of the room. Resident 11 pointed to Resident 14 and said "that's [him/her], [s/he's] weird and always comes into my room."

On 07/30/2025 at approximately 12:30 PM, Surveyor interviewed POAHC I who was Resident 11's activated POAHC. POAHC I voiced awareness of Resident 11 and others wandering around the facility. POAHC I stated s/he felt Resident 11 was usually looking for his/her past partner who Resident 11 thought was Resident 12. S/he said s/he feels that Resident 11 needs more supervision and not necessarily from Resident 12 as s/he sometimes could use more assistance with incontinence and redirection.

On 08/05/2025 at approximately 8:15 AM, Surveyor interviewed Ombudsman N who had recent frequent contact with Resident 11 and Resident 12. Ombudsman N stated over the months of March through June 2025, s/he observed multiple residents wandering into other resident rooms and Resident 11 wandering the halls and opening other resident room doors upon every visit. Ombudsman N voiced concern about overall supervision of residents in the facility, especially Resident 11. S/he said Resident 11 was always seeking Resident 12 out, but it seemed more out of dependency because s/he

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didn't know or "couldn't trust staff." Ombudsman N stated s/he felt that Resident 11 wasn't guided to meals and activities as s/he needed, rather staff would just "point" in the direction of the life enrichment room, but not make sure s/he got there. S/he indicated staff do not monitor Resident 11's whereabouts and were rarely seen present to redirect Resident 11 from others' apartments or other residents from entering Resident 11's room.

On 08/04/2025 at approximately 11:27 AM, Surveyor interviewed Director of Nursing (DON) J. Surveyor inquired about Resident 11 and whether or not s/he wandered or went into other resident rooms. DON J stated Resident 11 had a friend, Resident 12, who Resident 11 typically liked to look for. S/he said Resident 11 would walk around the building as well and did not always know where s/he was going. DON J said s/he believed at times Resident 11 did think Resident 12 was his/her past significant other.

RESIDENT 12
Surveyor reviewed Resident 12's record and noted s/he had diagnoses of Alzheimer's disease, type 2 diabetes, obstructive sleep apnea, and heart failure. S/he was independent with mobility with assistive devices and most activities of daily living (ADL's).

On 08/13/2025 at approximately 11:14 AM, Surveyor interviewed Power of Attorney for Healthcare (POAHC) M. POAHC M noted that s/he noticed most, if not all resident room doors were kept closed or locked. S/he indicated s/he could understand that they would keep their doors closed if others were going into their rooms unexpectedly. POAHC M stated Resident 12 kept his/her door locked at all times and was very

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adamant about it. S/he had a sign on the inside of his/her door to remind staff to lock the door as they are leaving so other residents do not go in. POAHC M indicated Resident 12 and Resident 11 were friends and stated s/he knew that Resident 11 was one of the residents who would go into others' rooms and could be confused about person and place.

RESIDENT 3
Surveyor reviewed Resident 3's record and noted s/he was admitted to the facility on 06/01/2024 with diagnoses of Alzheimer's disease, stage 4 kidney failure, congestive heart failure, and arthritis. Resident 3 had an activated POAHC, required assistance with most ADL's, and had a wanderguard.

Surveyor reviewed Resident 3's ISP with print date 07/30/2025 and noted:
"WANDERING/ELOPEMENT RISK - STAFF MONITOR REQUIRED. (Behavior Patterns/Wandering Risk) Directions: Provide supervision and redirection to avoid and prevent wandering episodes. If wandering occurs, determine follow-up plan. *Know his/her _whereabouts - redirect as needed.* Always have a family or staff member with them outside *Take note of his/her _ clothing daily to be able to describe him/her _ in the event of an elopement Resident will often say that [s/he] needs to go home. Use Distraction such as 'we can't go right now they are painting or remodeling.' Ensure them that [family member] will be visiting soon and that [s/he] knows where they are. Ask [him/her] to help with some things while [s/he] waits for [his/her] [family member] and redirect to an activity. Or ask [him/her] if you can come with and state that you have to go back to their room to grab somethings in order to go with."

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"30-MINUTE SAFETY CHECKS (Physical Health/Safety) ...Staff will check on residents safety every 30 minutes."

On 08/04/2025 at approximately 11:27 AM, Surveyor inquired with DON J about Resident 3 as Resident 11 and Resident 12 had mentioned him/her coming into Resident 11's room often. DON J said Resident 3 would typically walk around the building and not exactly know that it's not his/her room. DON J stated we try to individualize people's doors to make them more recognizable and Resident 3 specifically had a door hanger on his/hers. S/he indicated Resident 3 did not wander or go into others' rooms on purpose, "[s/he] just doesn't always know where [his/her] room is."

RESIDENT 14
Surveyor reviewed Resident 14's record and noted s/he was admitted to the facility on 10/15/2024 with diagnoses of dementia and polyneuropathy. Resident 14's ISP indicated s/he required 24- hour supervision, had an activated POAHC, required total assistance in all ADL's. Resident 14 had a wanderguard.

Surveyor reviewed Resident 14's most updated ISP with print date 07/30/2025 and noted: "PRN PSYCHOTROPIC MEDICATION USE ...Resident has PRN [as needed] for increased anxiety and agitation at times may get increased [sic] anxiety and restless generally when [significant other] is away from [him/her]. Reassure [him/her] that [significant other] is coming back. Family states to tell [him/her] that [his/her] [significant other] is at the Doctors or out Golfing. Family also reports that resident could have increased Paranoid thoughts such as 'worried about the house getting broke in to [sic]

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or the car getting stolen - (prior to move to facility) Reassure Resident that [s/he] is safe here at [his/her] home."
"WANDERING/ELOPEMENT RISK - STAFF MONITOR REQUIRED. (Behavior Patterns/Wandering Risk) Directions: Provider supervision and redirection to avoid and prevent wandering episodes. If wandering occurs, determine follow up plan. *Know his/her _whereabouts - redirect as needed* Always have a family or staff member with them outside *Take note of his/her _ clothing daily to be able to describe him/her _ in the event of an elopement. Resident may have increased anxiety and thinks [s/he] has to leave for [his/her] [significant other]. Reassure [him/her] that [significant other] will be returning and that [s/he] is either at the doctor's or golfing."
"30 MINUTE SAFETY CHECKS ... Staff to check on residents [sic] every 30 minutes."

On 08/04/2025 at approximately 11:27 AM, Surveyor inquired with DON J about Resident 14 who DON J described as living next to Resident 11 on the "enhanced care" side because s/he needed extra checking on. DON J said Resident 14 had a wanderguard due to his/her history of exit seeking and being very "highly mobile."

On 07/30/2025 at approximately 1:30 PM, Surveyor observed the enhanced care wing small dining room and noted an approximate 12-foot, red mesh Velcro door guard span with a "STOP" across Resident 13's doorframe.

On 08/04/2025 at approximately 11:27 AM, Surveyor interviewed DON J and inquired about the red mesh door guard on Resident 13's door and DON J stated "[s/he] doesn't want anyone to come in [his/her] room unless [s/he] invites them

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| N 426 | Continued From page 24<br>...[Resident 13] prefers it and feels an added sense of security with it."<br><br>On 07/30/2025, Surveyor reviewed the provider's "Wanderguard Policy & Protocol" and noted "The safety of our residents is always our priority. To ensure that all residents feel safe, and have a safe environment to reside in ...All new residents will be assessed by an authorized and trained staff member, prior to move in and again upon move in. Among other things, we will use this assessment to determine if they have a propensity to wander ...Any residents who are determined to have a propensity to wander will be issued a Wanderguard."<br><br>On 08/06/2025 at approximately 10:00 AM, Surveyors interviewed DON J and Regional Director (RD) K. Surveyors confirmed the Wanderguard system was for the exit doors and not for resident rooms. DON J acknowledged seeing Resident 11 walking around the building, but stated that s/he had never attempted to exit the building - "which is why [POAHC I] felt that a wanderguard for [Resident 11] was not necessary ...even though I felt [Resident 11] needed one. I have it documented."<br>DON J verified awareness of Resident 3 and Resident 14 having exit seeking and wandering tendencies including going into other resident rooms. DON J and RD K stated Resident 3 and Resident 14 have wanderguards and if they are by the door the staff do run to the door. "They [wanderguards] are working as they should."<br>DON J stated they were not aware that Resident 11 locked his/her door or that s/he was afraid of anyone coming in. DON J and RD K acknowledged concerns of residents going into other resident rooms. | N 426 | | |

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| N 426 | Continued From page 25<br>Cross Reference:<br>N0396 83.36(1)(a) Adequate Staff To Meet Resident Needs<br>N0431 83.38(1)(g) Health Monitoring | N 426 | | |
| N 431 | 83.38(1)(g) Health monitoring.<br><br>As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not monitor the health of 2 of 2 | N 431 | | |

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residents reviewed (Resident 1 and Resident 11). The provider did not make arrangements and document correspondence with the resident's physician and other healthcare providers for Resident 1 and Resident 11.

Resident 1 had diagnoses of diabetes and chronic kidney disease and had a routine lab visit on 05/27/2025 that resulted in elevated levels. The provider was notified to assist Resident 1 in scheduling a follow up visit with his/her physician multiple times. On 06/09/2025, Resident 1 began exhibiting inappropriate sexual behaviors towards staff and other residents. The provider did not implement interventions to prevent and/or manage his/her change in sexual behaviors. Resident 1's physician was not notified of his/her change in behaviors until 07/21/2025 and the provider did not assist Resident 1 in scheduling a follow-up visit for his/her labs.

Resident 11 had diagnosis of hypertension and required assistance from staff for medication administration and management. Resident 11 had orders for a blood pressure medication, hydrochlorothiazide, that was to be held based on blood pressure parameters set by Resident 11's physician. Resident 11's hydrochlorothiazide was held 3 times in May 2025, 5 times in June 2025, 8 times in July 2025 due to blood pressures outside of his/her parameters. Resident 11's physician was not updated regarding his/her blood pressures and medication being held, and were not aware of how often the physician should be notified. Resident 11 had been refusing medications, treatments, and assistance with activities of daily living (ADL's). Resident 11's physician was not notified of refusals and his/her ISP was not updated to reflect medication and treatment refusals or refusal of care assistance.

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| N 431 | Continued From page 27<br><br>Findings include:<br><br>On 03/12/2025, 03/13/2025, 03/26/2025 and 04/02/2025, the Department received complaints alleging care concerns, and concerns with health monitoring and behavior management.<br><br>On 07/30/2025 at 9:30 AM, Surveyors conducted an onsite visit to complete a verification visit and investigate 5 complaints. A sample of residents was selected including the records of Resident 1 and Resident 11.<br><br>RESIDENT 1:<br><br>Record Review<br>On 07/30/2025, 07/31/2025, 08/01/2025 and 08/04/2025, Surveyor requested and reviewed parts of Resident 1's record and identified the following:<br><br>Resident 1 admitted to the facility on 10/28/2024 with diagnoses to include but not limited to, chronic kidney disease and diabetes. Resident 1 had an activated power of attorney for healthcare (POAHC) and was identified as a fall risk.<br><br>Resident 1's most recent ISP with a print date of 07/30/2025 notes s/he "needs some supervision ...needs some assistance ...makes needs known." Resident 1 requires staff assistance with medication management, laundry services, housekeeping and as needed assistance with bathing/showering needs. Under "Behavior Patterns" and "Other Behavior," Resident 1's ISP reflects, "Family reports that Resident can be "extra friendly with [Fe/males]" Let Resident know that Comments are inappropriate and make it uncomfortable "I am not comfortable with that | N 431 | | |

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type of conversation and I need to focus on your Care" Redirect conversation to Resident needs/care Report Concerns to Director/On Call/MD [sic all]." The frequency of the "Other behavior - Sexuality" was "as needed every day."

Resident 1's active cares document reflects the "Other behavior - Sexuality" task was added to his/her service plan on 03/20/2025.

Resident 1's observation notes from 03/01/2025 to 07/30/2025 noted the following in part:
-- 03/26/2025, 2:02 PM, Other behavior - Sexuality: "Resident put hand on writers hip. Writer told resident that makes [him/her] uncomfortable, and we need to focus on getting [him/her] changed." Author: Resident Assistant (RA) B.
-- 04/14/2025, 10:30 AM, Observation note: "Received lab order for resident to be drawn on May 29th, 2025. Also to schedule appointment around that time also. HUC [sic] put labs on calendar and POA updated to schedule an appointment ..." Author: House Unit Coordinator (HUC) G.
-- 05/26/2025, 2:00 PM, Observation note: "Resident is scheduled for lab draw on 5/27/25. Resident is aware." Author: HUC G.
-- 05/27/2025, 3:30 PM, Observation note: "Received labs. Faxed to PCP [primary care physician] for review awaiting response." Author: HUC G.
-- 05/28/2025, 6:00 PM, Observation note: "PCP response - PCP noted - Needs follow-up visit/discuss lab results. Please call to schedule patient. Will follow up." Author: Assistant Director (AD) A.
-- 06/09/2025, 1:30 PM, Observation note: "Writer Observed. Writer noticed resident kissing [Resident 3] on the lips. Continue to chart

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updates." Author: HUC G.
-- 06/18/2025, 2:45 PM, Observation note: "Received labs PCP did state resident has dyslipidemia as noted in the blood test results of the lipid panel, with diabetes which is in good control, with chronic kidney disease with elevated creatinine level and also mildly elevated urine microalbumin and creatinine ratio. Please have [him/her] get a follow-up visit." Author: Administrative Coordinator (AC) C.
-- 07/17/2025, 12:00 PM, Observation note: "[Another resident] ...came to writer and said resident has [his/her] pants unzipped and playing with his [genitals] in the dining room. Writer went to resident and said that it's inappropriate to play with your [genitals] in the dining room. Please chart any behaviors." Author: HUC G.
-- 07/20/2025, 1:00 PM, Observation note: "behaviors: the past two days resident has been making inappropriate comments to staff ... tried kissing other residents ... tried unzipping [his/her] pants at the lunch table ... pulling [his/her] pants down and asking [another resident] to touch [his/her] [genitals]. writer took resident out of the area ... writer called and updated on-call. chart for anymore behaviors [sic all]." Author: RA U.
-- 07/21/2025, 8:00 AM, Observation note: "Resident behavior: While writer was taking residents blood sugar resident stated writer had nice [chest]. Continue to chart behaviors, will update PCP." Author: AC C.
-- 07/23/2025, 12:45 PM, Observation note: "Received Fax: PCP faxed back statin [sic] has [s/he] been told about this, explained to resident. Has anyone/admin, nursing staff reached out to POA or family. Resident is also supposed to get a follow up appointment and is overdue. Need follow up, make sure a family member is with [him/her]." Author: AC C.
-- Observation note: "LE [late entry] 7-23 overdue

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apt/behaviors - writer spoke with POA and said resident is overdue for a recheck and the doctor would also like a family member with [him/her], writer was told they are busy and may not have time to bring resident in and asked if resident could get a ua [sic] (because poa [sic] feels resident has been off lately) at the facility and if that's negative they will make an apt. to speak with the doctor about [his/her] behaviors and cover the overdue recheck - writer faxed doctor requesting a [urinalysis], waiting for response." Author: Administrative Assistant (AA) D. Completed 07/24/2025, 11:30 AM.
-- 07/29/2025, 1:15 PM, Observation note: "Behaviors: ... resident had [his/her] [genitals] out and was touching [him/herself] in the dining room. Writer approached resident and told [him/her] that what s/he] was doing was inappropriate .... Writer notified assistant director. Will continue to chart further behaviors." Author: Life Enrichment Coordinator (LEC) E.

Review of a "Physician Communication Form" dated 07/21/2025 from facility staff to Resident 1's physician states, "Resident has been sexually commenting on staff. [S/he's] been sexually displaying [him/herself] in the dining room. Any recommendations will be nice." The bottom of the form was completed and signed by Resident 1's physician on 07/22/2025 and states," "Has [s/he] been told about this, explained to patient. Has anyone/admin, nursing staff reached out to POA or family. Pt is also supposed to get a follow-up appointment + [sic] is overdue. Need follow-up. Make sure, a family member is with [him/her]." The top of the communication form reflects it was faxed back to the facility on 07/23/2025.

On 08/04/2025 at 10:22 AM, Surveyor sent an

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email to RD K requesting an update on Resident 1's urinalysis request from 07/23/2025. RD K responded at 11:34 AM stating, "Here are the new notes regarding the UA" and included an attachment of Resident 1's observation notes from August 2025.

Resident 1's observation notes from 08/01/2025 to 08/04/2025 noted the following:
-- 08/01/2025, 8:26 AM, Observation note: "LE [late entry] 7-31-25. Fax - Refaxed to pcp. Will follow up in the morning." Author: AD A.
-- 08/01/2025, 12:00 PM, Observation note: "update - No response to fax sent. resent fax again this morning. Then writer called pcp office at 10am. Nurse stated they were planning on sending lab orders and UA order to be reviewed at the August 22nd appointment. will chart updates." Author: AD A.
-- 08/01/2025, 3:30 PM, Observation note: "Orders - Received UA order and Lab order -PCP wrote Ok for UA- Get appt asap w/blood prior to visit - notified staff ..." Author: AD A.
-- 08/03/2025, 3:30 AM, Observation note: "Late entry (8/2/25): urine sample: urine sample was collected and brought to lab: wait for results." Author: RA U.

(Surveyor note: Per observation note, the provider faxed Resident 1's physician on 07/23/2025 requesting a urinalysis due to his/her behaviors. As of 07/30/2025, the date of Surveyor's onsite visit, the provider still had not followed up with Resident 1's physician on the urinalysis request.)

Review of Resident 1's updated lab order collected on 05/27/2025 noted the following:
-- 05/27/2025: "Patient was seen for [his/her] routine follow-up in January 29,2025. Here is the

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recommendation during that visit: Follow up in 4 months for follow up with: A1C, Lipid, CMP and Urine Microalbumin. Please have [him/her] get an appointment for routine follow-up visit. Will discuss the results of the blood test during that time."
-- 05/28/2025: "Fax sent to Bayview to assist patient with scheduling an appt."
-- 06/13/2025: "Message reprinted and faxed to Bayview to please assist patient with scheduling an appointment."
-- 06/13/2025: "Pending patient appointment. Please review and advise on labs."
-- 06/17/2025: "[S/he] has dyslipidemia as noted in the blood test results of the lipid panel, with diabetes which is in good control, with chronic kidney disease with elevated creatinine level and also mildly elevated urine microalbumin and creatinine ratio. Please have him get a follow-up visit."
-- 06/18/2025: "Printed and faxed to Bayview."

(Surveyor note: The provider was notified by Resident 1's physician's office on 05/28/2025, 06/13/2025 and 06/18/2025 of the need to assist him/her in scheduling a follow up appointment. Additionally, when the provider notified the physician on 07/21/2025 of Resident 1's behaviors, the physician responds on 07/22/2025 stating Resident 1 is supposed to get a follow up appointment and is overdue. As of 07/30/2025, the date of Surveyor's onsite visit, the provider still had not assisted Resident 1 in scheduling a follow up appointment. There is also no documentation to show the provider contacted Resident 1's POA to assist with scheduling a follow up appointment until 07/23/2025.)

Interviews
On 07/30/2025 at 11:20 AM, Surveyor interviewed

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Resident 7 who stated, "There is a [fe/male] resident who plays with [him/herself] during meals. [S/he] played with [his/her] [genitals] at the lunch table. I saw [his/her] [genitals]. I told staff something needed to be done as this was the second time and is not appropriate."

During an interview with Life Enrichment Coordinator (LEC) E on 07/31/2025 at 11:14 AM, s/he stated s/he assists with meals in both the main dining room and also in the memory care dining room. LEC E reported, "[Another resident] brought it to my attention [Resident 1] recently took [his/her] [genitals] out at the lunch table and was touching [him/herself] inappropriately. I spoke with [Resident 1] and asked [him/her] to put it away so no one had to experience that. I reported it to [AD A] who was already monitoring the situation and then I documented it." LEC E reported there were other incidents as well that other staff witnessed and addressed. LEC E stated, "This is a new behavior for [Resident 1] that I'm aware of. It started in May and is fairly new."

On 07/31/2025 at 11:26 AM, Surveyor interviewed Administrative Coordinator (AC) C who reported his/her job duties consist of communicating with physicians, filing and helping with resident cares. AC C stated, "Other staff have observed inappropriate things by [Resident 1]. [S/he] has made sexual comments towards [fe/male] staff. [S/he] told me I have nice [chest] during a medication pass. I told [him/her] that was inappropriate and [s/he] said [s/he] wouldn't do it again." AC C stated s/he has heard from other staff Resident 1 has played with his/her genitals at the lunch table. S/he reported, "The comments have happened before, but they have increased recently and gotten worse. The exposure is more

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recent."

During an interview with HUC G on 08/04/2025 at 11:14 AM, s/he stated s/he saw Resident 1 kiss Resident 3 on the mouth on 06/09/2025. HUC G reported when s/he saw this, s/he went over to Resident 1 and told him/her to not kiss Resident 3 as s/he is married. HUC G stated Resident 1 said s/he did not know that and went back to his/her room. S/he reported there have been other incidents where Resident 1 has played with his/her genitals in the dining room and also made sexual comments to staff. HUC G stated, "This is not typical behavior for him. It was new." S/he reported, "Staff were just documenting [his/her] behaviors, but it was happening more frequently so we decided to fax the physician." HUC G confirmed s/he and AC C notified Resident 1's physician of his/her behavioral concerns on 07/21/2025. HUC G reported when Resident 1's physician responded s/he wanted a follow up appointment with Resident 1 and his/her POA. S/he stated Resident 1's POA was contacted and wanted a urinalysis done because of the behaviors as s/he had never heard of him/her doing this before. HUC G stated, "The fax machine was not working initially, but we finally got the fax for the UA [sic]. The UA [sic] was obtained on Saturday [08/02/2025] and brought to the lab." HUC G was unsure if they received the urinalysis results.

On 08/04/2025 at 4:04 PM, Surveyor interviewed POA F who stated s/he was first told about Resident 1's behaviors in the middle to late July. S/he stated, "I was told [Resident 1] was playing with [him/herself] in the dining room. I didn't know what to say. It caught me off guard because it was out of character for [him/her]. It was alarming and never to this level before." POA F reported,

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"[Resident 1] has always flirted and been extra friendly with [others], but I was not aware of this happening before." POA F confirmed the facility did not reach out to him/her to schedule a follow up visit with Resident 1's physician regarding his/her labs from 05/27/2025 until recently when they reached out about his/her behaviors.

On 08/05/2025 at 1:40 PM, Surveyor interviewed Social Worker (SW) H who stated s/he witnessed the "long kiss" between Resident 1 and [another resident]. SW H reported the kiss was "uncomfortably long" and s/he felt the need to redirect Resident 1 to stop him/her from kissing the other resident.

During an interview with RD K and Director of Nursing (DON) J on 08/06/2025 at 10:00 AM, they stated Resident 1's ISP was updated on 03/20/2025 because his/her family reported s/he had a history of being "extra friendly with [fe/males]". DON J stated this was not reported upon Resident 1's admission and denied that it has been an issue since his/her arrival. RD K and DON J confirmed the first incident occurred on 03/26/2025 with a staff member and then on 06/09/2025 when Resident 1 kissed Resident 3. RD K confirmed Resident 1 was redirected and there was no follow up stating, "[Resident 1] didn't go after [him/her]. It was a mutual kiss. It was a confusion thing for [Resident 3]." DON J reported they redirect Resident 1 as much as they can and tell him/her it is not appropriate. DON J stated this is not a consistent thing for Resident 1 so they asked his/her physician for a urinalysis as they thought something else was going on. DON J confirmed Resident 1's urinalysis was negative and s/he has a follow up with his/her physician on 08/22/2025. DON J and RD K confirmed there have been no other sexual behaviors since

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| N 431 | Continued From page 36<br><br>07/29/2025. Surveyor reviewed the updates to Resident 1's lab order from 05/27/2025 which reflected notification to the provider from the physician's office on 05/28/2025, 06/13/2025 and 06/18/2025 which asks them to assist Resident 1 with scheduling an appointment. RD K stated, "I am sure staff followed up, but nothing is charted." RD K reported if it was charted the documentation would be in Resident 1's observation notes. RD K confirmed they did not have additional documentation to show they assisted Resident 1 and/or contacted his/her POA to schedule a follow up appointment with his/her physician. DON J and RD K also acknowledged Resident 1's ISP has not been updated since 03/20/2025 with the increased sexual behaviors and/or interventions.<br><br>Conclusion<br>Resident 1 had a routine lab visit on 05/27/2025 and results indicated s/he had elevated levels and a follow up was needed. On 05/28/2025, 06/13/2025, 06/18/2025 and 07/23/2025, Resident 1's physician's office notifies the provider of the need for a follow up visit. There are observation notes from 04/14/2025, 05/28/2025, 06/18/2025 and 07/23/2025 which reflect the provider was aware of the need for follow up visit. On 06/09/2025, Resident 1 experiences a change in condition when s/he starts to exhibit sexual inappropriate behaviors toward not only staff, but residents. On 07/23/2025, Resident 1's POA was notified of his/her behaviors and the need for a follow up visit. From 06/09/2025 to 07/29/2025, Resident 1's sexual behavior increases. From 05/28/2025 to 07/23/2025, the provider did not ensure Resident 1 received appropriate health monitoring to meet his/her needs when they did not assist him/her on scheduling a follow up visit | N 431 | | |

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with his/her physician after a routine lab visit on 05/27/2025.

RESIDENT 11:

On 07/30/2025, Surveyor reviewed Resident 11's record and noted s/he was admitted to the facility on 08/12/2024 and had an activated Power of Attorney for Healthcare. Resident 11's record did not include a listing of his/her diagnoses. Resident 11's May-July 2025 Medication Administration Record (MAR) listed medication reasons for use for "sleep ...anxiety ...blood pressure ...left foot wound." Resident 11 also received 2 other medications without a reason/diagnosis for use.

Blood Pressure Monitoring
Surveyor noted in Resident 11's MAR, s/he had an order for Hydrochlorothiazide 12.5 mg cap - take one capsule by mouth every day for blood pressure, hold for blood pressure < 100/60 (less than). Staff were to take Resident 11's blood pressure and administer hydrochlorothiazide if blood pressure was within parameters daily at 8:00 AM.
Surveyor noted the MAR had the following identifiers "REF" for refused (or didn't administer), "VIT" for low vitals, and "OTH" for other. Days listed as REF and OTH were referenced in observation notes. Days listed as VIT were listed in the MAR.

On 08/06/2025 at approximately 10:00 AM, DON J verified the identifiers on the MARs.

The following days Resident 11 did not receive hydrochlorothiazide due to his/her blood pressure being below 100/60. Surveyor noted Resident 11's MAR Notations and observation notes in

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conjunction with the MAR identifiers.

05/23/2025 (Observation Note) "No Pass: Other Problems held medication per PCP [primary care physician] orders"
05/29/2025 (MAR) Vitals
05/30/2025 (Observation Notes) "No Pass: Refused by Resident hold per order"
06/06/2025 (Observation Note) "No Pass: No pass per vitals Hold per order"
06/19/2025 (Observation Note) "No Pass: No pass per vitals Hold per order"
06/20/2025 (MAR) Vitals
06/28/2025 (MAR) Vitals
07/11/2025 (MAR Notation) "Hold per order"
07/12/2025 (MAR Notation) "Hold per order"
07/15/2025 (Observation Note) "No Pass: No pass per vitals hold per order"
07/17/2025 (MAR Notation) "No pass per vitals"
07/18/2025 (MAR Notation) "No pass per vitals"
07/21/2025 (Observation Note) "No Pass Reason: No pass per vitals Hold per order"
07/25/2025 (Observation Note) "No Pass Reason: No pass per vitals Hold per order"
07/29/2025 (Observation Note) "No Pass per vitals Hold per order"
Surveyor note: Resident 11's vitals were outside of parameters and s/he did not receive his/her hydrochlorothiazide as a result 16 times May-July 2025.

On 08/06/2025 at approximately 10:00 AM, Surveyors interviewed DON J and RD K. DON J stated Resident 11 had an order for hydrochlorothiazide and staff were to hold the medication if his/her blood pressure was below 100/60. Surveyor inquired whether Resident 11's physician was notified when his/her blood pressure was below the parameter and/or the medication was held and DON J stated s/he

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would have to look.

On 08/07/2025 at approximately 11:26 AM, RD K forwarded email correspondence from DON J stating "[Resident 11] had the parameters on when to hold the HCTZ [hydrochlorothiazide] but doctor did not indicate when [s/he] wanted to be updated." DON J wrote acknowledging needing to correct this and stated s/he "updated [his/her] care plan and added a task so that staff know to update MD [physician] when they have to hold [Resident 11's] med due to [his/her] BP [blood pressure] not being in the parameters to give ..." DON J also indicated s/he contacted the MD to notify him/her of Resident 11's vitals and medication holds recently.

Refusals
Surveyor noted Resident 11's ISP listed "staff to manage and administer medication. Report any side effects to physician. Family reports that Resident may often refuse to take medication."

Surveyor noted May-July 2025 MAR had the following identifier "REF" for Refused by Resident. Surveyor noted MAR Notation and observation notes indicating refusal by Resident 11 in conjunction with the MAR.
Surveyor noted Resident 11 had refused 11 medications and 3 physician ordered treatments from May-July 2025. MAR documentation reflected "Refused by Resident" and Resident 11 did not receive the medications.

On 07/30/2025 at approximately 10:00 AM, Surveyor interviewed Resident 11 who stated s/he did not take any medications. Resident 18 was present during the conversation and corrected Resident 11 stating, "yes, you do." Resident 11 said s/he sometimes refused them as s/he

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thought s/he did not need them and would "give them [staff] a hard time."

Surveyor note: Resident 11's physician was not notified of Resident 11's refusals of medications and prescribed treatments. Resident 11 was not re-assessed and his/her ISP was not updated to reflect interventions if Resident 11 were to refuse his/her medications and treatments.

Surveyor reviewed Resident 11's most updated ISP from April 2025:
"DRESSING - ASSIST ...Daily@ Morning, Evening, As Needed ...Requires monitoring and assistance as needed with dressing and undressing as well as choosing proper attire. Resident does not like to be cold and will layer several items. Report changes in skin condition. Offer body lotion with cares provided."
"TOILET CHECK - SCHEDULED ...Follow the toileting schedule and assist in monitoring and assisting ...assist with toileting needs. Report changes in urinary pattern ...Daily [every 2 hours]"

For each care task, staff were to document whether or not the task was completed. Surveyor reviewed Resident 11's May-July 2025 Task Administration Record (TAR) and observation notes and noted Resident 11 refused assistance with dressing or toileting 41 documented times from May-July 2025.

Surveyor note: Resident 11's physician was not notified of care task refusals, was not re-assessed for a change in care needs, and his/her ISP was not updated to reflect refusals in care tasks.

On 07/30/2025 at approximately 10:00 AM, Surveyor interviewed Resident 11 who stated s/he

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was able to dress him/herself and was able to toilet him/herself without troubles. Surveyor observed Resident 11 to be dressed appropriately for the weather inside, was free of odor, and did not have multiple layers of clothing on. Resident 11 implied that s/he appreciated his/her privacy and did not want anyone to assist him/her in the bathroom.

On 08/04/2025 at approximately 11:27 AM, Surveyor interviewed DON J who stated staff were to assist Resident 11 to the toilet to make sure s/he was clean and dry, to prevent a UTI (urinary tract infection). DON J said Resident 11 was not always cooperative with that. DON J indicated Resident 11 dressed him/herself, but needed reminders and help getting changed to ensure s/he had appropriate clothing and footwear on.

On 08/06/2025 at approximately 10:00 AM, Surveyors interviewed DON J and RD K. Surveyor inquired whether Resident 11's MD had been notified of his/her refusals. DON J stated s/he would have to refer back to Resident 11's chart. RD K stated they met with all parties involved for Resident 11 in April 2025 when his/her ISP was last updated. DON J stated Resident 11 wants to be as independent as possible, but sometimes wanted to put multiple layers of clothing on. Staff will try to get Resident 11 to the bathroom and s/he will appear somewhat offended if staff ask him/her. DON J indicated Resident 11 would say "I'm not a baby." DON J indicated Resident 11 has been more open to cares and thought s/he was not refusing as often since his/her April care review.

On 08/07/2025 at approximately 11:26 AM, RD K forwarded email correspondence from DON J

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| N 431 | Continued From page 42<br>acknowledging Resident 11's ISP was not updated to reflect care refusals and Resident 11's physician was not notified of refusals. DON J wrote "..what I have done to correct this...Updated [his/her] care plan and added a task so that staff know to update MD when... [s/he] should refuse to take a med." DON J indicated when Resident 11 was initially assessed, his/her [family member] did state that [Resident 11] was not good about taking his/her medications. "This has since improved since [his/her] admission greatly to what it was prior."<br><br>Cross Reference:<br>N0426 83.38(1)(b) Supervision | N 431 | | |
| N 489 | 83.44(2)(a) Rooms clean and free from odors.<br><br>The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors.<br><br>This Rule is not met as evidenced by:<br>Based on interviews, observations and record review, the provider did not ensure 4 of 4 resident rooms were clean and free from odors.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) I6MI11, dated 02/27/2024.<br><br>Findings include:<br><br>On 04/02/2025, the Department received complaint information alleging concerns with cleanliness and odors in resident rooms.<br><br>On 07/30/2025 at approximately 9:45 AM, Surveyors toured the facility and observed resident rooms, noting the following: | N 489 | | |

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| N 489 | Continued From page 43<br><br>On 07/30/2025 at approximately 9:59 AM, Surveyor observed Resident 2's room.<br><br>Surveyor observed a strong urine like odor when entering Resident 2's room. Surveyor observed Resident 2's room to have debris on the carpeted floor, an adult brief inside of a plastic wash bin next to the bed, (6) used vinyl gloves on the bathroom floor, used towels and/or washcloth rolled into a ball on the shower floor, bathroom counter cluttered with personal care items, a toothbrush and a kitchen fork. Sink was discolored, appeared to have liquid soap on the edge and some yellow discoloring inside the sink bowl. Toilet appeared to have urine in the toilet bowl and in a retainer, "hat" sitting on the rim of the toilet.<br><br>On 07/30/2025 at approximately 10:21 AM, Surveyors observed Resident 8's room.<br><br>Surveyor observed a strong urine like odor when entering Resident 8's room. Surveyor observed Resident 8's room to have debris on the carpeted floor and bed was unmade with the fitted sheet lifting from the mattress. Surveyor observed a soiled brief in Resident 8's bathroom garbage and bathroom floor had debris and brown colored spots near and around the toilet.<br><br>On 07/30/2025 at approximately 10:30 AM, Surveyors observed Resident 9's room.<br><br>Surveyor observed strong feces like odor when entering Resident 9's room. Surveyor noted the odor became stronger upon entry into Resident 9's bathroom. Surveyor observed Resident 9's toilet bowl had a brown substance stain and yellow staining on 50% of the shower floor. | N 489 | | |

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| N 489 | Continued From page 44<br><br>Additionally, Surveyor observed used towels and/or washcloths rolled into a ball on the shower floor.<br><br>On 07/30/2025 at approximately 10:35 AM, Surveyors observed Resident 10's room.<br><br>Surveyor observed a strong odor of uncleanliness and body odor when entering Resident 10's room. Surveyor observed piles of worn clothing on the floor in Resident 10's room. Surveyor observed a white memory foam pillow with yellow staining, a roll of toilet paper and a few piles of worn clothes on Resident 10's bed, near the headboard. Surveyor observed a brown substance stain in Resident 10's toilet bowl and his/her bathroom sink had hair strands, dust and a used washcloth inside the bowl of the sink.<br><br>On 07/30/2025 at 10:12 AM, Surveyor interviewed Housekeeper L who stated s/he works 5 days per week and does a deep clean to resident rooms once per week. Housekeeper L stated, "I was on vacation for 2 weeks and nothing got done. Staff put their names down to help while I was gone, but they did nothing. Cleaning is not getting done daily. I'm limited to what I can do. I've expressed concerns several times to [Assistant Director A] and nothing gets done. It took me 4 days to get it all cleaned up and that was only 1 side of the building. I haven't even gotten to the other side yet." Housekeeper L reported caregivers are supposed to change resident's bedding once per week and specifically on shower days. S/he stated, "That is not getting done. They mark it was completed in the resident's record, but it wasn't. I had my suspicions, so I marked a resident's bedding with a black spot to see if it was changed while I was gone. It was still there when I got back. The | N 489 | | |

| 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 _____ | R-C 08/13/2025 |

| 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 |
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| N 489 | Continued From page 45 | N 489 | | |

resident's bedding was not changed and it should be done weekly."

On 07/30/2025 at approximately 10:00 AM, Surveyor interviewed Resident 12 who was able to make his/her needs known. S/he required assistance with housekeeping and laundry. Resident 12 stated there was no one to complete tasks while Housekeeper L was on vacation. S/he said s/he had to beg a caregiver to do his/her laundry after a week and a half as s/he was running out of clothes. Resident 12 said there was no back up plan and not enough staff to fill in when Housekeeper L is off.

On 08/06/2025, Surveyor reviewed June and July 2025 staff schedule and noted Housekeeper L was off 06/28/2025 - 07/14/2025.

On 07/31/2025, Surveyors reviewed facility documentation identified as daily housekeeping tasks for caregivers. The documentation indicated the following " .... clean the rooms to the resident's satisfaction ...Pick up any clutter that is lying around, and put it away ... Take out trash from kitchen, bathroom(s) and bedroom(s), bringing it directly to the dumpsters ... Dust .... Clean toilet(s), bathroom sink(s) and bathtub(s) .... Remove dirty laundry per policy and begin doing it .... If the resident requests that you do something that is not on the above list, and is a reasonable request, you are to do it .... If a resident does not want their apartment cleaned, make note of it and chart ...."

On 08/05/2025 at approximately 3:30 PM, Surveyors interviewed Regional Director K (RD-K) who acknowledged Surveyors concerns regarding the lack of cleanliness of resident rooms.

| 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 _____ | R-C 08/13/2025 |

| 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 |
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| N 489 | Continued From page 46<br><br>Cross Reference:<br>N0396 83.36(1)(a) Adequate Staff To Meet Resident Needs | N 489 | | |