STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 03/24/2026, with additional information gathered through 03/31/2026, Surveyors investigated 3 complaints, conducted a standard survey and conducted 2 verification visits at Bayview Senior Care LLC for statement of deficiency (SOD) H03F11, dated 09/10/2025 and F32B12, dated 08/31/2025. The survey resulted in 5 deficiencies. Three of 3 complaints were substantiated. As a result of the verification visit for SOD H03F11, dated 09/10/2025, 4 of 4 previous deficiencies were corrected. As a result of the verification visit for F32B12, dated 08/31/2025, 3 of 4 previous deficiencies were corrected and 1 deficiency was a repeat violation. Four new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census 46	{N 000}		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by:	N 352		

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

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N 352	Continued From page 1 Based on record review and interview, the provider did not ensure 1 resident (Resident 27) received her/his prescribed medications at the interval prescribed by the physician. Findings include: On 11/03/2025, the Department received a complaint alleging residents were not receiving prescribed medications at the intervals prescribed by the physician. On 03/24/2026, at approximately 9:00 AM, Surveyor reviewed Resident 27's Individual Service Plan (ISP) and noted the following: Resident 27 was admitted to the facility on 10/09/2025 for respite care. Resident 27's diagnoses included hypertensive heart and chronic kidney disease with heart failure. Resident 27 received assistance from staff to manage and administer medications. On 03/30/2026, Surveyor reviewed Resident 27's Physician's order dated, 10/07/2025 for Midodrine HCL 5 MG Oral tablet "Indications: Blood Pressure Drop Upon Standing Take 10 mg (2 tablets) in the morning, then repeat every 4 hours x2 doses (for total of 10 mg three times daily). Do not take within 4 hours of laying down. Check BP before each dose, if BP >150/190, take half of scheduled dose. If BP >160/95, hold dose completely." On 03/26/2026 Surveyor reviewed Resident 27's October 2025 medication administration record (MAR) and noted the following: Midodrine 5mg Tab - take 2 tabs (10mg) by mouth every morning, then repeat every 4 hours for 2 more doses.	N 352		

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Check blood pressure before each dose. Do not take within 4 hours of lying down. If blood pressure is >150/90, take 1 tab (5mg). If blood pressure is >160/95, hold dose.

Resident 27's October MAR 2025 noted the following for Midodrine HCL 5mg TAB:

10/10/2025
8:00 AM - Midodrine HCL 5mg TAB - Administered at 8:34 AM
12:00 PM - Midodrine HCL 5mg TAB - *Administered at 11:29 AM
*2nd dose administered at 11:29 AM, which was 2 hours and 55 minutes after the 1st dose was administered. Surveyor noted administration was not 4 hours apart as indicated on order.

10/11/2025
8:00 AM - Midodrine HCL 5mg TAB - Administered at 10:11 AM
12:00 PM - Midodrine HCL 5mg TAB - *No medication passer initials. No timestamp.
4:00 PM - Midodrine HCL 5mg TAB - Administered at 4:48 PM
*Timestamps for administration are only displayed when the person administering initials the electronic MAR. Due to there being no initials to verify the medication administration for the 2nd dose, there was no timestamp to verify the required 4 hour minimum was followed between doses. For the doses to be administered every 4 hours, the total time between the 1st and 3rd dose would need to be 8 hours. The total time between the 1st and 3rd doses was only 6 hours and 37 minutes. This time difference would not allow the full 4 hours between doses.

10/12/2025
8:00 AM - Midodrine HCL 5mg TAB -

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N 352	Continued From page 3 Administered at 9:35 AM 12:00 PM - Midodrine HCL 5mg TAB - *Administered at 12:30 PM 4:00 PM - Midodrine HCL 5mg TAB - 06:21 PM (No med administered due to Blood Pressure (BP) 175/77) *2nd dose administered at 12:30 PM, which was 2 hours and 55 minutes after the 1st dose was administered. Surveyor noted administration was not 4 hours apart as indicated on order. 10/14/2025 8:00 AM - Midodrine HCL 5mg TAB - Administered at 7:44 AM 12:00 PM - Midodrine HCL 5mg TAB - Administered at 11:30 AM 4:00 PM - Midodrine HCL 5mg TAB - *Administered at the hospital (noted HOS) *On 03/31/2026, Surveyor interviewed DON-J, who stated HOS means they were in the hospital and verified Resident 27 was never in the hospital. 10/15/2025 8:00 AM - Midodrine HCL 5mg TAB - Administered at 7:46 AM 12:00 PM - Midodrine HCL 5mg TAB - Administered at 12:08 PM 4:00 PM - Midodrine HCL 5mg TAB - *Administered at the hospital (noted HOS) *On 03/31/2026, Surveyor interviewed DON-J, who stated HOS means they were in the hospital and verified Resident 27 was never in the hospital. 10/16/2025 8:00 AM - Midodrine HCL 5mg TAB - Administered at 10:08 AM 12:00 PM - Midodrine HCL 5mg TAB - *Administered at 12:43 PM	N 352		

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N 352	Continued From page 4 4:00 PM - Midodrine HCL 5mg TAB - **Administered at 7:40 PM *2nd dose administered at 12:43 PM, which was 2 hours and 35 minutes after the 1st dose was administered. Surveyor noted administration was not 4 hours apart as indicated on order. **3rd dose administered at 7:40 PM, which was 6 hours and 57 minutes after the 2nd dose. Surveyor noted administration was not 4 hours apart as indicated on order. 10/18/2025 8:00 AM - Midodrine HCL 5mg TAB - Administered at 10:24 AM 12:00 PM - Midodrine HCL 5mg TAB - *Administered at 11:57 AM 4:00 PM - Midodrine HCL 5mg TAB - 4:15 PM (No med administered due to BP 169/83) *2nd dose administered at 11:57 AM, which was 1 hour and 33 minutes after the 1st dose was administered. Surveyor noted administration was not 4 hours apart as indicated on order. 10/19/2025 8:00 AM - Midodrine HCL 5mg TAB - Administered at 9:31 AM 12:00 PM - Midodrine HCL 5mg TAB - *Administered at 11:47 AM 4:00 PM - Midodrine HCL 5mg TAB - 04:20 PM (No med administered due to BP 163/83) *2nd dose administered at 11:47 AM, which was 2 hours and 16 minutes after the 1st dose was administered. Surveyor noted administration was not 4 hours apart as indicated on order. On 03/26/2026, at approximately 12:45 PM, Surveyor interviewed Director of Nursing J (DON-J). DON-J confirmed medications are to be administered as prescribed by the physician. DON-J stated staff are trained to call the on-call	N 352		

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nurse if a medication cannot be administered as prescribed allowing the on-call nurse to instruct how to proceed.

On 03/31/2026, at approximately 8:50 AM, Surveyor interviewed Regional Director K (RD-K) and DON-J. DON-J acknowledged Resident 27's medication was not consistently administered as prescribed. DON-J confirmed educating staff to notify the on-call nurse when medication cannot be administered as prescribed.

The Mayo Clinic stated the following:

"Midodrine is used to treat low blood pressure (hypotension). It works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten. As a result, blood pressure is increased."

"The last dose of Midodrine should not be taken after the evening meal or less than 3 to 4 hours before bedtime because high blood pressure upon lying down (supine hypertension) can occur, which can cause blurred vision, headaches, and pounding in the ears while lying down after taking this medicine."

(Source: The Mayo Clinic Website, Drugs & Supplements, Side Effects and Dosage, Drug information provided by: Merative, Micromedex®, Portions of this document last updated: March 01, 2026, https://www.mayoclinic.org/drugs-supplements/midodrine-oral-route/description/drg-20064821 (retrieval date - March 30, 2026)

Resident 27 was prescribed Midodrine HCL. The order specified the medication was to be taken 4 hours apart. Resident 27 received several doses

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N 352	Continued From page 6 that was not within the 4 hour timeframe.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure prompt and adequate treatment was provided for Resident 11 and Resident 26. This is a repeat deficiency. See SOD (Statement of Deficiency) Z0F911 dated, 01/17/2023. On 01/16/2026, the provider sent a fax to Resident 11's physician requesting an order for a urine analysis (UA) due to symptoms of urinary tract infection (UTI). On 01/16/2026, the physician returned the fax with an approval for the UA order. The provider did not obtain the UA. On 01/19/2026, Resident 11 was taken to the emergency department (ED) where s/he was diagnosed with a UTI and influenza A 3 days after the approved order for the UA and identification of symptoms. On 01/03/2026, Resident 26's primary care physician (PCP) was notified by fax about Resident 26's unwitnessed fall. On 01/04/2026, Resident 26's PCP was notified by fax of a groin rash. On 01/06/2026, the PCP returned the fax advising Resident 26 should go to the emergency	N 353		

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department (ED) regarding the fall. Resident 26 was taken to the ED on 01/07/2026. Upon arrival to the ED, Resident 26 was found to have a full body rash, a stage II pressure wound and dehydration.

Findings include:

On 01/08/2026 and 01/29/2026, the department received a complaint alleging residents did not receive prompt and adequate treatment.

RESIDENT 11

On 03/24/2026, Surveyor reviewed Resident 1's ISP, with the print date of 03/24/2026. The ISP identified the following:

Toileting: Resident 11 required 2-hour checks for toileting and incontinence. Report changes in urine color, odor and frequency.

Communication: Resident 11 required assistance with communicating needs or ideas. Resident 11 was unable to make these needs known. Resident 11 could follow simple directions.

On 03/25/2026, Surveyor reviewed faxes sent from the provider to Resident 11's physician. The faxes noted the following:

Fax from provider to PCP
01/16/2026 (Friday): "Resident confused, paranoid, tired sleeps most of the day and has been more incontinent of urine also has been complaining of lower back pain and is off balance."

Fax from PCP to provider
01/16/2026 (Friday): "Have UA & culture drawn

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N 353	Continued From page 8 please" signed on 01/16/2026. On 03/25/2026 at 12:24PM, Surveyor interviewed Family Member V. Family Member V explained s/he went to visit Resident 11 on Monday, 01/19/2026. Upon arrival, Family Member V described Resident 11's condition. Resident 11 was sitting at table near the dining room. Family Member V recalled Resident 11 was slumped over with his/her head hanging down. Family Member V stated, "[S/he] did not seem like [his/herself]." Family Member V recalled Resident 11 had a fever. Family Member V stated permission was obtained from the activated power of attorney for Family Member V to transport Resident 11 to the ED. Family Member V explained the ED diagnosed Resident 11 with a UTI and the flu. Family Member V reported the emergency department had to give Resident 11 an injection of Rocephin in both thighs. On 03/25/2026, Surveyor reviewed Resident 11's ED medical record for 01/19/2026. The documentation noted the following: "History of Presenting Illness" "Chief complaint: pt presents to ER (emergency room) with family who have concern of UTI or infection due to change of behavior including increased lethargy, and increased confusion that are noted from family ....pt is a [age/gender] ... with severe dementia ...patient has had a fever and cough. [S/he] has been acting differently from [his/her] baseline dementia ...family is concerned about a possible UTI. [S/he] has had these in the past ..." "ED Course" "Urinalysis and blood work was also obtained. I spoke to the power of attorney (POA) who was	N 353		

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present ...Patient's urine is consistent with infection. Patient is to have [his/her] having trouble [sic] with oral medications because of cooperation from patient. They [POA] stated an IV may be very difficult. We will give IM Rocephin ..."

"Clinical Impression"
"Influenza A, Urinary tract infection, Dementia"

According to the Mayo Clinic Rocephin is the brand name for ceftriaxone. The May Clinic stated, "Ceftriaxone is used to treat bacterial infections in many different parts of the body ..."

Information was obtained on 03/26/2026, at 1:22PM at:
https://www.mayoclinic.org/drugs-supplements/ceftriaxone-injection-route/description/drg-20073123

The Cleveland Clinic noted the following about UTIs:
"The best thing to do for a urinary tract infection is to see a healthcare provider. You need antibiotics to treat a UTI."

Information obtained on 03/26/2026 at 10:22AM from:
https://my.clevelandclinic.org/health/diseases/9135-urinary-tract-infections

On 03/26/2026, at 10:15AM, Surveyor interviewed Registered Nurse W (RN-W). RN-W identified s/he is one of the RN's for Resident 11's primary care physician (PCP). RN-W reported they PCP's office received a fax on 01/16/2026 requesting a urine analysis (UA) order for Resident one due to suspicion of a UTI. The request for the order was approved and faxed to the facility on 01/16/2026. RN-W confirmed they

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did not receive results of the UA until 01/19/2026, when the ER obtained it.

On 03/31/2026, at 8:30AM, Surveyor interviewed Director of Nursing J (DON-J) regarding change of condition. DON-J explained when a caregiver notices a change in condition during after hours, they should notify the provider's designated on-call person for direction. DON-J added, direction given to caregivers depends on the specific situation. DON-J reported, s/he preferred if there is suspicion of a UTI and a need for a UA, the resident should be sent to an urgent care instead of sending a fax for an order, specifically over weekends. DON-J described the reason for this preference was because it is difficult to get an order over the weekend and the urgent care can get results and prescribe medication faster.

On 01/16/2026 (Friday), the provider noticed Resident 11 was exhibiting symptoms of a possible UTI. The provider sent a fax to the physician requesting an order for a UA. The order for the UA was sent back to the provider on 01/16/2026, but the urine was not collected and sent of for analysis. On 01/19/2026, Family Member V noticed Resident 11 did not look well and transported Resident 11 to the ED. The ED diagnosed Resident 11 with a UTI and influenza A. Resident 11 did not receive treatment for 3 days after the identification of a change in condition.

RESIDENT 26

On 03/24/2026, Surveyor reviewed Resident 26's Individual Support Plan (ISP), with a print date of 03/24/2026. The ISP identified the following needs:

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N 353	Continued From page 11 Bathing: Resident 26 needed full assistance with bathing including, "dressing and undressing, wash, shampoo ..." The ISP also identified any changes in skin condition should be reported. Dressing: Resident 26 needed full assistance with dressing. The ISP also identified any changes in skin condition should be reported. Toileting: Resident 26 wore incontinence pads and required 2-hour checks for incontinence. On 03/25/2026, at approximately 8:10AM, Surveyor reviewed faxes sent from the provider to Resident 26's PCP and return faxes from the PCP to the provider. The faxes noted the following: FAX REGARDING FALL Fax from provider to PCP 01/03/2026: "[Resident 26] had an unwitnessed fall. [Resident] off [his/her] recliner and onto the floor .... Weak and unsteady ..." Fax from PCP to Provider: Signed by physician on 01/05/2026 but received by the provider on 01/06/2026 at 8:50PM 01/06/2026: "Recommend eval (evaluation) in ER since [s/he] is not improving." FAX REGARDING GROIN REDNESS Fax from provider to PCP 01/04/2026: "[Resident 26's] groin is raw and red. Could we get an order for nystatin powder?" Fax from PCP sent to provider: signed on 01/05/2026 and received by the provider on 01/06/2026	N 353		

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Use terbinafine cream (OTC) twice daily for 1 month. Control moisture with nystatin powder twice daily. Swab groin [illegible]/culture (wound culture) to rule out bacterial infection."

On 03/25/2026, at approximately 8:45AM, Surveyor reviewed Resident 26's observation notes and noted the following:

01/07/2026: "Call from [Resident 26's] POA (power of attorney) from yesterday's (01/06/2026) message writer left to update [him/her] about [Resident 26]. Writer told POA that [Resident 26] has not improved and now is having trouble holding [his/her] head up, POA wants resident to be evaluated ...emts (emergency medical technicians) were called ..."

On 03/25/2026, Surveyor reviewed Resident 26's primary care nursing communication notes, for 01/07/2026 and 01/08/2026. The nursing notes identified the following:

Communication from the ED to PCP's office on 01/07/2026
" ...Based on a fax we had received from Bayview, we advised on Tuesday that the patient be seen in the ED. Patient presented to ED via ambulance with a confusing report from EMS (emergency medical services). Chief complaint: Groin rash. Patient was actually advised to go to the ED after a fall.

Communication from the ED to PCP's office on 01/08/2026
" ...Of note from the ED visit: ...care center had to get a hold of power of attorney which took 48 hour prior to being authorized to send patient in for further evaluation ...POA is not activated. Per [Physician Assistant X], [s/he] does not feel it is

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(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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appropriate to activate POA at this time, and will reassess at the upcoming appointment ...

Note: Review of the faxes between the provider and PCP showed the facility received the fax to send Resident 26 to ER on 01/06/2026 at 8:50PM. The ED documentation below showed Resident 26 arrived at the ED on 01/07/2026 at 2:42PM. This was actually approximately an 18-hour delay.

The ED communication further noted, " ...notes more concerns than just the groin rash ...notes that [s/he] has skin issues on [his/her] face, chest, and belly button. [S/he] also has a stage III pressure ulcer on [his/her] coccyx ..."
Note: The ED report below noted the pressure ulcer was a stage II.

On 03/25/2026, Surveyor reviewed the document titled, "Illinois Statutory Short Form Power of Attorney for Health Care, dated 11/21/2022 and confirmed Resident 26's power of attorney was not activated.

On 03/25/2026, at approximately 3:25PM, Surveyor interviewed Regional Director K (RD-K). RD-K reported Resident 26's family member identified s/he was the activated power of attorney in Illinois, but not in Wisconsin. RD-K concluded the status was entered as activated and was never changed in the provider's system.

On 03/25/2026, at 10:46AM, Surveyor interviewed Registered Nurse Y (RN-Y), the nurse for Resident 26's PCP. RN-Y confirmed the PCP's office faxed the provider on 01/06/2026 advising them to send Resident 26 to the ED due to the unwitnessed fall reported on 01/03/2026. RN-Y further stated, Resident 26 was not brought

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N 353	Continued From page 14 to the ED until 01/07/2026. On 03/26/2026, Surveyor reviewed Resident 26's ED report dated, 01/07/2026. The ED report noted the following concerns: " ...multiple areas of skin breakdown, redness, incontinent ...Apparently patient has been refusing cares last 2 to 3 days time. Apparently care center had to get a hold of power of attorney which took 48 hours prior to being authorized to send patient for further evaluation...Patient has been uncooperative for care so has not gotten much care for skin wounds in the last couple days time ...Patient not exactly sure why [s/he] is here ..." Note: Review of the faxes between the provider and PCP showed the facility received the fax to send Resident 26 to ER on 01/06/2026 at 8:50PM. The ED documentation showed Resident 26 arrived at the ED on 01/07/2026 at 2:42PM. This was actually approximately an 18-hour delay. "Erythema of the umbilicus (navel area) and area around the umbilicus with moist discharge ...Nursing staff report patient has grade 2 pressure ulcer perirectaly...Patient has erythematous ulcerated type lesions which apparently are chronic. [S/he] also has evidence of intertrigo (skin rash caused by friction and moisture) in the lower abdominal skin fold as well as in the groin region and umbilicus ..." "Blood pressure is low today so we will give [him/her] a liter of IV fluid ...Will check appropriate labs as differential diagnosis must include urosepsis, sepsis from wounds verses Canida infection wounds. Also I will check a CT scan	N 353		

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N 353	Continued From page 15 because of the increased confusion ...Total protein and albumin are slightly high which would go along with dehydration ... On 03/26/2026, Surveyor reviewed Resident 26's follow-up visit with his/her PCP regarding the ED visit on 01/08/2026. The follow-up noted the following: " ...follow-up visit regarding recent events at [his/her] facility and an ER (emergency room) visit. Received a fax from this facility the week of 1/5/26 regarding groin rash ...I had them do a swab for culture. It grew staph (staphylococcus bacteria) and proteus (bacteria). [S/he] was started on Augmentin bid x 10 days based on sensitivity testing ..." According to the Cleveland Clinic, Staphylococcus is described as: "Staphylococcus (staph) is a group of bacteria. There are more than 30 types. A type called Staphylococcus aureus causes most infections ... Some people carry staph bacteria on their skin or in their noses, but they do not get an infection. But if they get a cut or wound, the bacteria can enter the body and cause an infection. Staph bacteria can spread from person to person. They can also spread on objects, such as towels, clothing, door handles, athletic equipment, and remotes ..." Information obtained on 03/30/2026 at 1:40PM from: https://my.clevelandclinic.org/health/diseases/21165-staph-infection-staphylococcus-infection On 03/31/2026, at 8:30AM, Surveyor interviewed Director of Nursing J (DON-J) regarding change of condition and notifications. DON-J explained when a caregiver notices a change in condition	N 353		

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N 353	Continued From page 16 during after hours, they should notify the provider's designated on-call person for direction. DON-J added, the caregivers could be directed to send the resident to the ED. DON-J described the reason for this preference was because it is difficult to get an order over the weekend and the urgent care can get results and prescribe medication faster than waiting on physician communication. On 01/06/2026, Resident 26's PCP advised for him/her to be seen in the ED due to not improving after an unwitnessed fall that occurred on 01/03/2026. The provider received the fax on 01/06/2026 at 8:50PM. The provider did not transport Resident 26 to the ED until 01/07/2026 at 2:42PM. This was approximately 18 hours after receiving the fax from the PCP due to waiting for permission from the family member identified as Resident 26's activated power of attorney. Record review revealed Resident 26 did not have an activated power of attorney. Upon arrival at the ED, Resident 26 was found to have a skin infection affecting various places on his/her body, a stage II pressure wound and dehydration. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 353		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the Individual Support Plan (ISP) was implemented	N 388		

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N 388	Continued From page 17 and followed as written for Resident 9 Findings Include: On 03/25/2026, Surveyor reviewed Resident 9's ISP, dated 10/14/2025 and updated active cares. The ISP identified Resident 9 was diagnosed with the following: mild traumatic brain injury, mild dementia, balance problems and Parkinsons Disease. The ISP and active cares noted the following regarding Resident 9's needs: Physical Disabilities - Active cares updated on 11/11/2025: Resident 9 required caregivers to assist with transfers. Bathing: Active cares updated on 03/13/2026: Required full assistance wish showers including hands-on assistance with washing, shampooing and reporting changes in skin condition. Hair Care: "Resident will be well groomed on daily basis" Dressing: Prompting to get dressed and undressed and report changes in skin condition. Toileting - Active cares updated on 02/01/2026: Resident 9 experienced incontinence of bladder. Resident 9 required caregivers to initiate toileting. Caregivers needed to conduct toileting checks every 2 hours. On 03/24/2026, at approximately 10:00AM, Surveyor entered the building and passed the first hallway to Surveyor's right-hand side. Surveyor smelled a strong urine like odor from the hallway. Surveyor observed residents waiting to receive podiatry services. Surveyor noted the odor was	N 388		

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N 388	Continued From page 18 from Resident 9. Surveyor also observed a white substance resembling dandruff on the shoulder of Resident 9's shirt. At 11:54AM, Surveyor observed Resident 9 sitting in the hallway after receiving podiatry services. Resident 9 still had a urine like odor. At approximately 12:10PM, Surveyor observed Resident 9 in the dining room for lunch and s/he still had a urine like odor. On 03/24/2026, at 3:20PM, Surveyor interviewed Caregiver AA. Caregiver AA confirmed Resident 9 was incontinent and needed 2-hour checks. Caregiver AA explained there are days when Resident 9 is more incontinent than others. Caregiver AA reported s/he has not noticed anything resembling dandruff. On 03/24/2026, at 3:22PM, Surveyor observed Resident 9 in the activity room playing Bingo. Surveyor observed Resident 9 smelled of urine like odor. At approximately 3:25PM, Surveyor observed a Caregiver AA radio a caregiver to attend to Resident 9. On 03/31/2026, at 8:30AM, Surveyor exited the survey with Regional Director K and Director of Nursing J. Regional Director K and Director of Nursing J acknowledged the findings. Resident 9 was observed to have an odor resembling urinary incontinence and a white substance on his/her shirt resembling dandruff. Resident 9's ISP noted s/he is on a 2-hour toileting schedule and receives assistance showering and dressing. The ISP further noted reports in skin changes (dandruff like substance) should be reported. Resident was odorous from approximately 10:00AM to 3:22PM.	N 388		

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N 389	Continued From page 19	N 389		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) was updated when there was a change in a resident's needs for Resident 26. Resident 26 was seen in the emergency department (ED) on 01/07/2026. The ED noted Resident 2 was refusing cares with the provider. Resident 26 was found to have areas of skin breakdown, redness and incontinence. Additionally, Resident 26 had a state II pressure wound. On 01/14/2026, Resident 26 had a follow-up appointment where test results determined the skin breakdown had staphylococcus. Resident 26 continued to refuse to receive cares after his/her return from the ED. The ISP was not updated for interventions regarding Resident 26's resistance to cares. Findings Include:	N 389		

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N 389	Continued From page 20 On 010/08/2026, the department received a complaint alleging residents were not being provided with personal cares. On 03/24/2026, Surveyor reviewed Resident 26's Individual Support Plan (ISP), with a print date of 03/24/2026, and updates to the active cares from the provider's electronic record. The ISP and active cares identified the following needs: Bathing - active cares updated on 02/05/2026: Resident 26 needed full assistance with bathing including, "dressing and undressing, wash, shampoo ..." The ISP and active cares also identified any changes in skin condition should be reported. Dressing - active cares updated on 02/05/2026: Resident 26 needed full assistance with dressing. The ISP also identified any changes in skin condition should be reported. Toileting - active cares updated on 12/26/2024: Resident 26 wore incontinence pads and required 2-hour checks for incontinence. Skin Assessment - active cares updated 02/05/2026: The instructions stated while shower Resident 26, caregivers should examine Resident 26 from head to toe for "skin tears wounds, redness or irritation." Skin Care Management - Arms/ Chest - active cares updated 01/05/2026: Instructions noted Resident 26 had scabs scattered on upper arms, check, and legs. It directed caregivers to report any complications including, increase in swelling, redness, pain, warmth to the surrounding skin of the wound ..."	N 389		

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N 389	Continued From page 21 Skin Care Management GROIN - active cares updated on 01/05/2026: Instructions noted "RESIDENT TO HAVE PERI AREA WASHED AND DRIED GROIN IS PINK. It directed caregivers to report complications including increase in swelling, redness, pain, warmth to the surrounding skin of the wound ..." Self-Abusive - Staff monitoring required - active cares updated on 02/05/2026: " ...encourage [Resident 26] to be involved in care [Resident often declines care from staff - Stating I don't want people that are younger taking care of me or States that I can do it on my own [Resident 6] made aware/Remind of the increased risk for infection hospitalization [sic]." Ambulation: Resident 26 used a walker and gait belt. The ISP identified Resident 26 had the following diagnosis: Adult failure to thrive, presence of left artificial shoulder and anxiety. On 03/24/2026, at approximately 3:20PM, Surveyor interviewed Caregiver AA. Caregiver AA reported Resident 26 declines help with cares and does not take care of him/herself. Caregiver AA reported Resident 26 would not change his/her incontinence products or clothes as much as s/he should. Caregiver AA explained if caregivers continue to try to provide assistance, s/he will tell them to "get the [expletive] out of my room." On 03/25/2026, Surveyor reviewed Resident 26's observation notes. The observation notes showed several instances of Resident 26 refusing cares on the following dates and times:	N 389		

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N 389	Continued From page 22 TOILETING 01/03/2026 at 11:00AM 01/05/2026 at 6:13AM and 01/05/2026 at 7:45AM 01/08/2026 at 1:00PM 01/09/2026 at 3:09PM 01/10/2026 at 12:00PM 01/13/2026 at 6:45AM and 1:50PM 01/15/2026 at 2:54PM and 5:12PM 01/16/2026 at 4:53PM and 7:50PM 01/19/2026 at 11:57AM 01/20/2026 at 8:31AM, 10:00AM, 7:15PM, 8:03AM, 10:45AM and 01/21/2026 t 8:03AM and 10:45AM 01/24/2026 at 8:16AM 01/25/2026 at 8:03AM 01/26/2026 at 8:20AM, 11:07AM and 1:03PM 02/06/2026 at 4:26AM, 9:36AM, 9:45AM and 02/06/2026 at 4:26PM 02/07/2026 at 2:31AM and 11:24PM 02/09/2026 at 9:26AM and 9:57AM 02/09/2026 at 10:39AM: "staff x3 have went into room multiple times to get [Resident 26] up and changed ..." 02/09/2026 at 10:47AM: "staff x3 tried to assist [Resident 26] with toileting ...eat time stating I will go in a little bit ..." 02/10/2026 at 12:27AM, 2:30AM and 4:46AM 02/11/2026 at 8:49AM, 10:04AM and 3:03PM 02/13/2026 at 2:20AM, 5:36AM, 10:05AM and 10:55PM 02/15/2025 at 2:54AM 02/16/2026 at 12:21AM and 1:35PM 02/17/2026 at 9:50PM 02/18/2026 at 6:20AM, 9:57AM, 10:15AM and 12:44PM 02/19/2026 at 8:31PM 02/21/2026 at 4:48AM and 10:22PM 02/22/2026 at 6:31AM: "stated [s/he] did not need to go."	N 389		

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N 389	Continued From page 23 02/23/2026 at 6:49AM: "I just took myself" 02/24/2026 at 12:25AM and 2:43AM 02/25/2026 at 2:29AM and 3:13PM 02/27/2026 at 12:31AM, 4:24AM 6:06PM and 9:06PM 03/01/2026 at 5:05AM 03/03/2026 at 2:24AM 03/06/2026 at 5:02AM 03/07/2026 at 4:26AM and 8:46AM 03/11/2026 at 4:39AM, 9:47AM and 2:42PM 03/12/2026 at 4:19AM 03/13/2026 at 2:38AM 03/14/2026 at 6:51AM 03/15/2026 at 2:23AM 03/16/2026 at 3:11AM 03/17/2026 at 7:34AM 03/20/2026 at 5:18AM 03/21/2026 at 8:38AM 03/23/2026 at 3:20PM 03/24/2026 at 6:59AM DRESSING 02/06/2026 at 9:40AM 02/07/2026 at 11:22PM 02/08/2026 at 11:10PM 02/09/2026 at 10:39AM 03/02/2026 at 10:51AM: "[Resident 26] stated 'I should be fine' when writer offered to help change clothes." SKIN CARE MANAGEMENT 01/09/2026 at 6:33PM: Groin "writer had to attempt multiple times ...refused ...say I can do it myself, leave me alone, I am tired." 01/20/2026 at 7:30PM: Groin "[Resident 26] stated I can take care of myself." 02/09/2026 at 10:46AM: "staff x3 tried to check areas and [Resident 26] stated they are fine ..." 02/15/2026 at 7:59PM: "does not want legs lotioned."	N 389		

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N 389	Continued From page 24 BATHING 01/26/2026 at 8:15AM: was reminded of groin rash needing to heal 01/26/2026 at 1:45PM: " ... [Resident 26] told writer to get the [expletive] out. Writer tried multiple times ..." 02/09/2026 at 10:40AM: "[Resident 26] stated I will do it when I want, you guys don't tell me ..." 02/16/2026 at 12:37PM: "Refused ...told writer [s/he] had washed [him/herself] with a washcloth ..." 03/09/2026 at 11:39AM ADDITIONAL NOTES 02/09/2026 at 11:30AM: "multiple staff have tried to get [Resident 26] up out of the bed to toilet, go to meals and take a shower. [Resident 26] has declined help each time. [Resident 26] states I am able to take care of myself. [Resident 26] have told staff to leave [his/her] room ...staff have reapproached or changed faces. [Resident 26] is getting more agitated when staff go in there ..." 02/18/2026 at 10:45AM: "Writer has tried multiple times this morning to bring [Resident 26] to the bathroom and get resident dressed .... told writer [s/he] does not need staffs [sic] help and [s/he] is sick of this place and all the workers trying to get [him/her] to do things. Writer explained why [s/he] should have assistance ..." On 03/26/2026, Surveyor reviewed Resident 26's ED report dated, 01/07/2026. Resident 26 was seen in the ED on 01/07/2026. The ED report noted Resident 26 was uncooperative for cares and is at risk for skin breakdown. The ED report noted the following concerns: " ...multiple areas of skin breakdown, redness,	N 389		

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N 389	Continued From page 25	N 389		

incontinent ...Apparently patient has been refusing cares last 2 to 3 days time ...Patient has been uncooperative for care so has not gotten much care for skin wounds in the last couple days time ..."

"Erythema of the umbilicus and area around the umbilicus with moist discharge ...Nursing staff report patient has grade 2 pressure ulcer perirectaly...Patient has erythematous ulcerated type lesions which apparently are chronic. [S/he] also has evidence of intertrigo in the lower abdominal skin fold as well as in the groin region and umbilicus ..."

On 03/26/2026, Surveyor reviewed Resident 26's follow-up visit with his/her PCP regarding the ED visit on 01/08/2026. The follow-up noted the following:

" ...follow-up visit regarding recent events at [his/her] facility and an ER (emergency room) visit. Received a fax from this facility the week of 1/5/26 regarding groin rash ...I had them do a swab for culture. It grew staph (staphylococcus bacteria) and proteus (bacteria). [S/he] was started on Augmentin bid x 10 days based on sensitivity testing ..."

On 03/31/2026, Surveyor interviewed Director of Nursing J (DON-J) and Regional Director K (RD-K). DON-J and RD-K acknowledged the findings.

On 01/07/2026, Resident 26 was seen in the ED. Resident 26 had skin breakdown on multiple areas of the body and groin as well as a stage II pressure wound. The ED notes from 01/14/2026 noted Resident 26's skin culture was positive for 2 different bacteria (staphylococcus and proteus).

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 03/31/2026

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 389	Continued From page 26 Review of Resident 26's observation notes revealed Resident 26 was resistive to personal cares including toileting, showering and skin checks. This continued to occur through March of 2026. Resident 26's refusals increases his/her risk of contracting additional skin breakdown. The most current update to Resident 26's ISP/active cares was on 02/05/2026.The ISP was not updated to provide interventions for Resident 26's refusals for care. Cross Reference N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment	N 389		
{N 489}	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on interviews, observations and record review, the provider did not ensure 2 of 2 resident rooms were clean and free from odors. This is a repeat deficiency. See Statement of Deficiency (SOD) F32B12 dated 08/13/2025 and SOD I6MI11, dated 2/27/2024. Findings include: On 03/24/2026 at approximately 10:00 AM, Surveyors toured the facility and observed resident rooms, noting the following: On 03/24/2026 at approximately 11:50 AM and 2:00 PM, Surveyors observed Resident 24's room.	{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 03/31/2026

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{N 489}	Continued From page 27 Surveyors observed a pungent urine-like odor when entering Resident 24's room. Surveyors did not observe the physical source of the odor such as soiled items or visible waste. Surveyor returned to Resident 24's room at 2:00 PM and the urine-like odor continued to permeate the room. On 03/24/2026 at approximately 11:51 AM and 2:01 PM, Surveyor observed Resident 26's room. Surveyors observed a pungent urine-like odor when entering Resident 26's room. Surveyors did not observe the physical source of the odor such as soiled items or visible waste. Surveyor returned to Resident 26's room at 2:01 PM and the urine-like odor continued to permeate the room. On 03/24/2026 at approximately 10:25 AM, Surveyor interviewed Housekeeper L who stated s/he works 5 days per week, and Housekeeper Z works 4 days per week. Housekeeper L stated, "I was on vacation for the past 2 weeks so it will take a bit to get caught up. It has gotten better having a second housekeeper and the overnight shift helping with laundry, but some resident rooms need a deep clean since I just returned from vacation." On 03/31/2026, at 8:30AM, Surveyors exited the survey with Regional Director K and Director of Nursing J. Regional Director K and Director of Nursing J acknowledged the findings.	{N 489}		