STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019533	A. BUILDING: _____ B. WING _____	R-C 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MEADOWS SENIOR LIVING	2800 N CALHOUN RD BROOKFIELD, WI 53005

(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 12/16/2025 to 12/23/2025, Surveyor conducted a complaint investigation and verification visit at Sunrise Meadows Senior Living. Three deficiencies were identified. The previous deficiencies from Statement of Deficiency (SOD) DM7011, dated 02/06/2025 were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. Census: 46	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the legal representative and physician of Resident 2 was immediately notified when there was an incident affecting the resident.	N 169		

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

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N 169	Continued From page 1 Resident 2's legal representative and hospice team were not notified of new bruising found on 02/05/2025. Findings include: On 11/18/2025, the Department received a complaint alleging concerns with resident falls. On 12/16/2025, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted to the facility on 11/12/2024 with diagnoses included type 1 diabetes and dementia. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 2's individual support plan (ISP) dated 11/12/2024 documented: "-Communication with Family/Representative: Emergency Contact or resident representative [Legal Representative L]. Staff will contact in case of emergency. -Mental Status: Resident requires additional cueing due to impaired judgement." Resident 2's hospice notes documented: "-02/05/2025 Incident Report: Facility stated patient had no bruises on Wednesday after breakfast, but when community care case managers came in patient had bruises and said that [s/he] had fallen nothing was witnessed no observed fall facility did not notify hospice. [Hospice F] aid found bruises on right shoulder left upper arm above left eyebrow left chin and neck with neck slightly swollen on 2/7/25 during cares. Writer stressed to facility to always notify about hospice of any injuries or bruises or possible falls.	N 169		

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N 169	Continued From page 2 Writer did not [sic] notify [Legal Representative L], who also was unaware that patient had bruising. Safety plan of care was discussed with facility. -02/07/2025: [Hospice F] aide reported new bruises on patient. Patient had stated [s/he] fell. Writer made visit. Patient's vital signs: 126/73 for BP, pulse 58, O2 saturation 90%, with 18 respiration. Patient has bruise that is yellowing on right upper arm and left eyebrow area. Patient also has bruise on left upper arm and patient has bruises on left side of chin and neck left side of neck is slightly swollen. Patient states [s/he] fell when [s/he] went outside. Unsure of date writer checked ..., who is unsure of patients fall-checked with [Administrator A] who is stated on Wednesday patient was fine when [s/he] came out to breakfast and when community care workers came to see [him/her] for a visit at 2 PM. [S/he] had the bruises. States it's presumed that [s/he] fell however they are not certain of this. States "[s/he] does go into all the other residents rooms as well" and "[s/he] has been more unstable on [his/her] feet". Writer and hospice aid examined patient for further injuries. Patient has no pain and no discomfort. Writer informed [Legal Representative L], who was unaware patient had any bruising. Facility instructed to call [Hospice F] with any questions concerns or changes in status. Safety plan discussed with facility personnel. Facility also to call back at your hospice with any suspected falls or new bruising or injuries." On 12/16/2025 at 11:45 AM, Surveyor interviewed Administrator A regarding Resident 2's bruising found on 02/07/2025. Surveyor asked about hospice notes indicating hospice and Resident 2's legal representative never being notified of new	N 169		

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N 169	Continued From page 3 bruising. Administrator A reported Resident 2's bruising was not seen at lunch on 02/05/2025, but later in the afternoon, when Resident 2 met with his/her case manager, bruising was seen by staff. Administrator A noted Resident 2 must have fallen but was not completely sure. Administrator A acknowledged Resident 2's record did not contain documentation his/her legal representative or hospice team was made aware on 02/05/2025 when first observed by provider staff. On 12/23/2025 at 1:41 PM, Surveyor interviewed Hospice Nurse I. Hospice Nurse I reported one of their aides found new bruising on Resident 2 while working with him/her on 02/07/2025. Hospice Nurse I stated s/he followed up with Administrator A who reported bruising was seen on 02/05/2025 when Resident 2 was meeting with his/her case management team. Hospice Nurse I confirmed hospice and Legal Representative L were never made aware of the new bruising until the hospice aide discovered the injuries.	N 169		
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,	N 389		

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N 389	Continued From page 4 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 Resident 2's individual service plan (ISP) was accurate to his/her condition and needs. Resident 2's ISP was not updated to include his/her need for hospice services, assistance with toileting, bathing, and dressing. Findings include: On 12/16/2025, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted to the facility on 11/12/2024 with diagnoses included type 1 diabetes and dementia. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 2's ISP dated 11/12/2024 did not document the need for hospice services or required assistance with toileting, bathing, and dressing. A review of the provider's care task report for January to February 2025 for Resident 2 documented: "-Bathing/showering: the resident requires assistance for bathing/showering, washing hair, body drying, body lotion. The care task report indicated this task being completed 2x/week. -Dressing: the resident needs assistance for dressing. Resident will need help with picking out weather appropriate clothing. The care task report	N 389		

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N 389	Continued From page 5	N 389		

indicated this task being completed 2x/day.
-Toileting: the resident requires assistance for toilet use check and change. The care task report indicated this task as being documented 1x/shift."

Surveyor reviewed hospice records which indicated Resident 2 began hospice care on 01/08/2025. Hospice records documented the following:
"-01/02/2025: Writer was called to facility to evaluate for possible hospice ...Patient has had declines in [his/her] ADLs and is needing more and more assist. Patient now also requires a mechanical soft diet as [s/he] has increased difficulty in chewing. Patient now requires 4/6 assist with ADLs. Patient's PPS is currently 40%. Cognitively, Patient has been having increased confusion and tends to wander at night. Patient is alert to only person at this time, not to place or time.
-01/09/2025: Writer saw patient for a 24 hour follow up visit. Patient was sitting in common area and was assisted down to [his/her] room patient was assisted on toilet where [s/he] had a large BM. Patient was stumbling with [his/her] walker walking down the hall and needed standby assist of one."

On 12/16/2025 at 1:30 PM, Surveyor shared concerns with Administrator A that Resident 2's ISP did not reflect an accurate description of his/her needs. Administrator A acknowledged Resident 2's ISP did not contain an accurate description of his/her toileting, bathing, and dressing needs and was never updated to include hospice services. Administrator A stated the facility was in between nurses during Resident 2's admission and s/he did not know all the features of their electronic health record. Administrator A

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N 389	Continued From page 6 stated since the provider hired a new nurse in July 2025, all care plans had been updated.	N 389		
N 426	83.38(1)(b) Supervision. 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that supervision appropriate to Resident 2's needs was provided in relation to his/her assessed fall risk and history of repeated falls since s/he was admitted to the provider on 11/12/2024. From 12/29/2024 to 02/15/2025, Resident 2 experienced 7 falls. Falls on 02/14/2025 and 02/15/2025 led to substantial negative outcome. Resident 2 passed away on 02/15/2025. Findings include: The provider is licensed to care up to 52 residents in the following client groups: irreversible dementia/Alzheimer's, advanced age,	N 426		

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N 426	Continued From page 7 developmentally disabled, and emotionally disturbed/mental illness. On 11/18/2025, the Department received a complaint alleging concerns with resident falls. On 12/16/2025, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted to the facility on 11/12/2024 with diagnoses included type 1 diabetes and dementia. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 2's individual support plan (ISP) dated 11/12/2024 documented: "-Mobility: Resident is ambulatory. Transfers self independently. Resident has been identified as a fall risk. Interventions in place to prevent falls: frequent checks, encourage non-slip socks in room, encourage proper footwear when out of bed, keep pathways in room clear of clutter." Resident 2's progress notes documented: "-12/29/2024: Resident was found on the floor in [his/her] room by care staff. Resident could not verbalize why or how [s/he] had fallen. Resident was assessed and found to have no injuries or pain. Resident was assisted to [his/her] sofa and [his/her] family was notified of fall. Resident's [daughter/son] arrived at the facility and requested that [s/he] be sent to the hospital because [s/he] couldn't walk and they were concerned about the edema in [his/her] lower legs which had been addressed by NP. -02/09/2025: Unwitnessed fall-staff reported that resident had bruising to left hand and wrist and complained of pain when wrist is moved. [Hospice F] NTFD. Resident unable to recall what had	N 426		

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N 426	Continued From page 8	N 426		

happened. [Hospice F] stated to use cool compress and Tylenol. If pain persists or Tylenol not working to use PRN morphine.
-02/14/2025: 504 am resident fall resulting in head injury. Staff went into room to do final round and get resident dressed for the day. Resident was found on the floor lying on [his/her] left side facing the cabinet holding a brief. Visible head injury. Swelling/bruising on right side of face, right was eye [sic] swollen shut. Hospice was notified at 5:10a. Nurse came to community and assessed. Resident was moved into bed, morphine was administered. Family was called by [Hospice F] and family declined hospital treatment or being sent out. Hospital bed and fall matt ordered and in house. @ 1605: Hospital bed and fall matt ordered and brought in. Resident resting comfortably in bed. Is able to walk to bathroom and make [his/her] toileting needs known. Can also raise hips up to adjust brief. Resident did not want to move head and stated [his/her] head hurts and is fearful of moving side to side. Cannot chew well, was fed Ensure, pudding, applesauce and bananas.
-02/15/2025: Unwitnessed 15:54. Medication aide came from changing another resident and noted legs and feet down the hallway. Aide observed resident laying face down in hallway and doorway on the ground. Resident was actively bleeding from [his/her] right eye socket with vomit coming from [his/her] mouth and nose. Pulse very faint, resident began to turn blue and was very pale. [Hospice F] pronounced the resident @ 1634."

Resident 2's frequent safety check documentation was charted once each shift (1st, 2nd, 3rd). The following dates did not have safety checks completed at the end of each shift: 01/03/2025

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N 426	Continued From page 9 (1st shift), 01/04/2025 (2nd shift), 01/05/2025 (2nd shift), 01/06/2025 (1st shift), 01/10/2025 (3rd shift), 01/11/2025 (3rd shift), 01/13/2025 (3rd shift), 01/14/2025 (1st shift), 01/15/2025 (2nd shift), 01/16/2025 (2nd shift), 01/19/2025 (2nd shift), 01/26/2025 (3rd shift), 01/28/2025 (1st shift), 01/29/2025 (1st shift), 01/31/2025 (3rd shift). Resident 2's hospice notes documented: -01/09/2025: ...[S/he] was admitted to hospice services on 1/8/25 with primary diagnosis of heart failure. Patient has diagnosis of dementia and [s/he] reports often feeling anxious and occasionally feelings depressed. Patient is alert and oriented to self only at this time, [his/her] POA is activated and the primary agent is [his/her] [son/daughter], and [his/her] code status is do not resuscitate. [Resident 2] has been admitted to the hospital multiple times in the last few months, most recently was last week when [s/he] was sent to the ER because [s/he] was having increased fluids in [his/her] legs and in [his/her] lungs. At 7:00 AM: Patient was using [his/her] walker and had walking assist of facility aid but did stumble in the hallway-aid caught patient so [s/he] did not fall, but patient did hit [his/her] head on the wall. Patient had no injury. Patient was examined and had no injury. No complaint of pain. Facility did not notify [Hospice F] until 10:30 AM. Stated they took vitals and neurochecks and patient had no change and was at baseline. -01/16/2025: Writer had just been with patient who was sitting on couch, and went out to get printed bed sheets returned to room and patient was on floor. Patient was sitting on [his/her] buttocks like [s/he] slid down however walker was upside down on floor and slippers were off. When writer asked patient if [s/he] had a fall patient stated no, but it	N 426		

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N 426	Continued From page 10	N 426		

appear that [s/he] had a fall. Writer got assistance with lifting, and they also stated they believe [s/he] fell. No injuries were noted- denies all pain and discomfort.
-01/27/2025: Patient now is attempting to walk with [his/her] walker, but steady on [his/her] feet was told to always call for assistance. Facility states patients been coming out of [his/her] room to eat again since Friday -stated [s/he] is unstable on [his/her] feet and [s/he] has been instructed that [s/he] needs to have someone walk with [him/her] state. ...facility if they use chair alarms at this facility, however facility stated no they are not allowed to have chair alarms. Patient appears weaker and more fatigued since this last episode of influenza. Facility staff states [s/he] has been sleeping more but has been comfortable.
-01/31/2025: Patient has recovered from influenza type a, however, [s/he] still remains weak and unstable on feet and still become short on breath with ambulating with [his/her] walker and assist. A wet, moist cough remains.
-02/03/2025: Writer saw patient for a visit. Patient remains slightly unsteady on feet. Patient still has cough from influenza A infection, but cough has improved. Patient still has end expiratory wheeze's in upper lobes bilaterally. Patient states [s/he] does feel better than [s/he] did last week. companionship time spent with patient, patient taken to dining room-patient is unstable on her feet with walker writer informed facility personnel that [s/he] may need walk by assist-writer inform patient to always ask for assist when [s/he] stands. Facility states [s/he] is now more wheelchair bound and does not walk as much. Patient was in good spirits stated [s/he] was pain-free. No changes to care plan at this time.
-02/07/2025: [hospice agency] hospice aide

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N 426	Continued From page 11	N 426		

reported new bruises on patient. Patient had stated [s/he] fell. Writer made visit. Patient's vital signs: 126/73 for BP, pulse 58, O2 saturation 90%, with 18 respiration. Patient has bruise that is yellowing on right upper arm and left eyebrow area. Patient also has bruise on left upper arm and patient has bruises on left side of chin and neck left side of neck is slightly swollen. Patient states [s/he] fell when [s/he] went outside. Unsure of date writer checked with ...[Administrator A] who is stated on Wednesday patient was fine when [s/he] came out to breakfast and when community care workers came to see her for a visit at 2 PM. [S/he] had the bruises. States it's presumed that [s/he] fell however they are not certain of this. States "[s/he] does go into all the other residents rooms as well" and "[s/he] has been more unstable on [his/her] feet". Writer and hospice aid examined patient for further injuries. Patient has no pain and no discomfort. Writer informed [son/daughter], who was unaware patient had any bruising. Facility instructed to call [Hospice F] with any questions concerns or changes in status. Safety plan discussed with facility personnel. facility also to call back at your hospice with any suspected falls or new bruising or injuries.
-02/09/2025: Writer was called to see patient who had fallen in [his/her] room and now is complaining of left hand/ wrist pain. Upon arrival patient observed laying in bed with wheelchair unlocked in middle of room and walker on the other side of the room next to couch. When asked patient does not remember how [s/he] fell, and staff report that [s/he] "must have fallen when [s/he] tried to take [him/herself] to the bathroom" Patient easily awakens to verbal stimuli. Vs taken: t 96.9. 162/58 p98 r 20 95%ra. Left hand has Bruise on top of hand from thumb to middle finger. Complains of

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N 426	Continued From page 12 Pain when asked to squeeze writers hand, and c/o pain in wrist when moved. Patient did receive prn Tylenol at 4:15pm just after fall and then routine dose of Tylenol at 7pm. Patient continued to offer complaints of pain/ discomfort to staff prior to 7pm dose of Tylenol. Writer updated med passer of vitals and c/o pain. Also reviewed medication orders for pain control and encouraged staff to use 1/2 morphine tab if pain continues. Writer also placed locked wheelchair next to bed for a safe transfer option and reminded patient to use call bell to get help to get up. -02/10/2025: Writer saw patient for a visit and post follow up for fall of yesterday. Patient is walking more stable on feet today. Patient does need to be reminded to keep walker with [him/her] and call for assistance went up. Patient denies all pain. Patient has good range of motion of both wrists, hands and fingers. Bruise is noted on left hand from fall of yesterday. Yesterday complained of wrist pain post fall, today has no pain. Companionship time spent. Writer did assist patient to dining room, patient was more stable when using walker -patient was able to feed [him/herself] with no difficulty. Patient was in good spirits, and smiling during visit. Teaching provided during visit: Writer updated facilities that patient will need someone to monitor and toilet at least every hour otherwise patient attempts to get up on [his/her] own. Discussed side rails and bed alarm with [Administrator A] from facility who stated they were not allowed at facility. Writer also discussed having patient in a wheelchair in the common area for better observation during the daytime hours. -02/14/2025 @ 5:09 AM: Received telephone call from [Caregiver G], facility caregiver, reporting patient had unwitnessed fall at approx 0500. Per [Caregiver G], [s/he] believes patient was	N 426		

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N 426	Continued From page 13 attempting to walk to the bathroom unassisted when [s/he] fell. Patient is now bleeding from left side of face. Per [Caregiver G], [s/he] cannot describe the wound because [s/he] saw [s/he] had fallen and was bleeding and [s/he] came to call hospice right away. [Caregiver G] states [his/her] coworker is with the patient at this time. This writer instructed [Caregiver G] to apply pressure to patient's wound and that a hospice nurse will come see the patient. This writer instructed [Caregiver G] that if they can feel they can safely get [him/her] back to bed they could otherwise they should leave the patient where [s/he] is and try to make [him/her] comfortable on the floor until the nurse arrives by providing patient pillow and blanket if possible. [Caregiver G] verbalized understanding and will. @ 5:19 AM: Received telephone call from [Administrator A], reporting that [s/he] received telephone call from [Caregiver G], reporting patient had a really bad fall and they were told to get patient back to bed by hospice and they don't think can get [him/her] back to bed. This writer instructed [Administrator A] that writer did instruct [Caregiver G] that [s/he] could get patient back to bed if [s/he] thought it was safe but if [s/he] didn't feel [s/he] could, patient should be left on the floor and made comfortable until the hospice nurse gets there. [Administrator A] also inquiring how hospice will handle such a bad fall. [Administrator A] states [s/he] is not currently at facility and has not seen patient after fall to know how bad patient's injuries are but [Caregiver G] described to [him/her] as very bad. This writer instructed [Administrator A] that [Hospice F] nurse is on [his/her] way to the facility at this time and assess patient and discuss with POA next steps. This writer instructed [Administrator A] that patient is a hospice patient and the goals are usually to	N 426		

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N 426	Continued From page 14 keep the patient at facility and to keep them comfortable. [Administrator A] verbalized understanding and understands that [Hospice F] nurse will see patient to assess and develop plan with POA. @ 6:05 AM: Writer was called to see patient who had fallen in [his/her] room and hit [his/her] head on the dresser. Upon arrival patient observed laying on the floor near [his/her] dresser and counter. Patient is laying on [his/her] back with knees bent and feet near couch. Patient does have dried blood on face and in hair. ROM completed to all extremities. Neuro checks completed, pupils equal and reactive. Hand grip strength equal. Patient does complain of pain in back of head. Patient assisted to sitting position, and is very anxious due to pain as evidence by vocal complaints of head and neck pain and guarding of head with hands and facial grimacing. Non verbal pain scale of 7/ 10. Reassurance given along with PRN Morphine 7.5mg. Writer and staff member assisted patient to wheelchair ....Blood on face and head cleaned with ns. Head laceration is approximated on its own. Scab is forming. Triple antibiotic ointment applied and area left open to air. Large bump, half of a golf ball size, observed above right eye and eye is almost swollen shut and black and blue in color. Writer attempted to put cool compress to area and patient continued to refused and was very jumpy and anxious. Vs taken: 163/116 p 120. T 97.2. R. 22. Writer assisted patient to get dressed. Patient requested to go out to dining room for breakfast. Patient did drink half a glass of juice and then requested to go back to room to lay down due to pain and discomfort in head. About 45 mins later, Writer requested additional PRN morphine 7.5 mg dose for pain that has not been controlled with initial dose as evidence by verbal complaints of pain,	N 426		

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N 426	Continued From page 15 guarding head and neck movements, facial grimacing, and increased restlessness and anxiety. Non verbal pain scale 7/10 Writer assisted patient back to her room and assisted patient in bathroom. Patient urinated on toilet again and complained that it hurt when [s/he] urinated. Urine appears very cloudy and has odor. Writer assisted patient back to bed. [Hospice Nurse I] updated on fall and patient condition. POA notified of fall and patient condition. Writer review all treatment options with POA: send patient to hospital for full work up (includes signing hospice revocation to cover hospitalization and then sign back on to hospice when discharged from hospital), keep patient "home" and possibly get portable X-rays done if symptoms don't improve and also provide pain management, or keep patient home and keep comfortable/ pain management. POA states they don't want to send patient to hospital and would like to keep patient home and comfortable. Writer also discussed ordering hospital bed to help with positioning and bed mobility. Family agreeable to getting hospital bed. Med passer updated on condition and plan moving forward along with [Hospice Nurse I] and family. Education provided to facility staff on safe transfers with wheelchair or if steady and able to walk, using walker. Also educated on different pain signs and symptoms to watch for, what meds to use and when to call Hospice (uncontrolled pain, vomiting, unresponsive, etc). and instructed to call [Hospice F] with any questions, concerns, or changes in condition. [Hospice Nurse I] will see patient later this am to follow up. @ 7:15 AM: Writer was notified by on-call who was with patient that patient had a fall. Patient did have a posterior occipital laceration less than 1/2 inch that was previously bleeding but has since stop bleeding.	N 426		

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N 426	Continued From page 16 Patient does have a new bruise on [his/her] right knee. Patient does have swelling and a bruised and swollen right eye and right cheek area. Facility staff thinks patient was on [his/her] way to the bathroom without [his/her] walker when [s/he] slipped and fell. Patient was having moderate amount of pain in the back of [his/her] head and was given morphine 7.5 mg . Pain persisted as did patient's anxiety. Patient was given second dose of morphine 7.5. Hospice on call nurse assisted patient to the bathroom and then returned [him/her] to bed. Writer will do follow up visit this morning. On call nurse will call and inform family. [Hospice Nurse H] States patient is having trouble turning [his/her] neck both ways and turns with [his/her] shoulders as [s/he] does have some neck pain. [Hospice Nurse H] will notify family at this time and see if family prefers revocation to go to ER or if management and treatment at facility is acceptable. Family does prefer to keep patient at facility. High low bed was ordered as was fall mat, with son's permission. [Hospice Nurse H] on call nurse noticed patients urine was very cloudy and foul. @ 9:10 AM: ...[Administrator A] stated [s/he's] never had a fall with a patient on hospice that's has an injury related and they usually send patients out however, [s/he's] in total agreement that if family does not want anything else done they could make patient comfortable. Facility encouraged to check on patient every hour for comfort/ pain assessment-[Administrator A] did not want scheduled morphine every hour at this time ....Writer again asked if bed rails or bed alarm could be used at facility and was told these could not be used there due to regulations ...Suggested to facility staff to monitor patient Q1 hour for pain if pain is not managed to call [Hospice F]. @ 4:00 PM: .... Writer spoke with [Administrator A] asking	N 426		

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N 426	Continued From page 17 if patient could be checked on every hour during the evening for pain management and if [his/her] pain got worse, that writer indicated pain meds could be scheduled or possibly a pain patch. Stated [s/he] would let us know if scheduled meds for pain need to be ordered but currently both writer and [Administrator A] agree that Patients pain is controlled and patient appears comfortable. Writer collaborated with [Administrator A] on ways to prevent falls and increased patient safety such as having bed in low position having fall mat by bed, checking on patient frequently, letting patient's door remain open at all times. -02/15/2025: Writer received call from triage nurse at 1600 who stated that the facility reported the patient had an unwitnessed fall and was found in the hallway. The staff reported to the triage nurse that when the patient was found, [s/he] was on the floor of the hallway unresponsive. [His/her] face was very bruised, that it appears that [s/he] vomited and that [his/her] skin looks "blue" and they were unable to find a pulse. When writer arrived at the facility at 1627, the patient was seen lying on the floor of the hallway, surrounded by 3 staff members. The patient was lying on [his/her] right side with [his/her] back up against the wall of the hallway, with [his/her] head on a pillow. The patient was unresponsive, appeared very pale in color and [his/her] face was severely bruised, swollen and bleeding. The patients eyes were swollen shut, [s/he] was bleeding from [his/her] right eye, from the bridge of [his/her] nose and [his/her] nostrils. The patient had 2 very large hematomas on [his/her] forehead. On the right side of [his/her] forehead, the swelling was continuing to grow causing a large bulge. Underneath [his/her] head and on the pillow appeared to be a pool of blood and vomit. The	N 426		

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N 426	Continued From page 18 patients mouth was open with [his/her] tongue sticking out slightly. When the writer asked the staff members what happened, the staff reported "the caregiver who was passing medications went into the patients room to give [his/her] morphine for pain. The patient took the medication and when the caregiver left the room the patient was asleep. The next time the caregiver looked into the hallway [s/he] noticed the patients feet and ran down to assess the patient which is when they found [him/her] face down on the floor of the hallway. They then called [Hospice F] directly after finding the patient, they also called the family members to notify them of the fall. The caregivers stated that they think the patient walked out of her room and into the hallway, where [s/he] fell and presumably hit [his/her] face on the wall or handrail of the hallway." The writer then listened for an apical pulse for 3 minutes with no heartbeat heard on auscultation. No spontaneous breaths were noted during those 3 minutes. Writer pronounced time of death at 1634. The writer then had staff members assist in transferring the patient back to her bed. The family arrived very shortly after the patient was moved back to [his/her] bed. The writer noticed the family of the patients passing. Writer then called the medical examiner of Waukesha County to report the incident and patient passing. Describe Injury: The patient appeared very pale in color and [his/her] face was severely bruised, swollen and bleeding and [s/he] was unresponsive. The patients eyes were swollen shut, [s/he] was bleeding from [his/her] right eye, from the bridge of [his/her] nose and [his/her] nostrils. The patient had 2 very large hematomas on [his/her] forehead. On the right side of [his/her] forehead, the swelling was continuing to grow causing a large bulge."	N 426		

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N 426	Continued From page 19 Waukesha County Medical Examiner's External Examination report dated 02/17/2025 indicated Resident 2's cause of death was displaced C2 vertebral fracture. Evidence of injury documented: "1) Extensive bruising to the face involving the forehead, both orbital areas, and the right cheek. This bruising is mainly purple-red over 13 cm transversely and 10 cm vertically. 2) Within the area of bruising is a 0.5 cm abrasion above the medial right eyebrow, a 0.8 cm laceration to the medial right orbit. 3) The right cheek is swollen. 4) There is a 5 x 2 cm red bruise to the left side of the chin. 5) 1 cm abrasion left side of nose. 6) 1.5 x 1.5 cm abrasion right side of the nose. 7) 6 x 5 cm red-brown bruise to the lateral right shoulder. 8) 4 x 4 cm green bruise top of the left shoulder. 9) 9 x 4 cm green bruise upper left chest. 10) 3 x 3 cm yellow-red bruise lateral upper left arm. 11) 2.5 x 3.5 cm red bruise anterior left hip. 12) 15 cm area of bruising to the radial aspect of the left hand and wrist. 13) 13 x 11 cm area of red bruising to the ulnar aspect of the left lower arm extending posteriorly. 14) 10 x 6 cm faint blue bruise to the anterior upper right thigh. 15) 14 x 11 cm red bruising across the right knee, more lateral than medial. 16) 2 cm scab left knee. 17) 2 x 3 cm green bruise left knee." On 12/16/2025 at 11:45 AM, Surveyor interviewed Administrator A regarding Resident 2's fall risk. Administrator A confirmed Resident 2 was a fall risk since s/he admitted. Administrator A stated due to Resident 2's dementia s/he would often forget to use his/her walker and would transfer without assistance after falls. Surveyor asked if the provider had evidence of hourly checks on Resident 2 that hospice recommended as early as 02/10/2025. Administrator A stated the provider did	N 426		

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not have evidence of hourly checks, only frequent checks that were documented as 1 occurrence at the end of each shift. Surveyor asked how the provider could ensure hourly checks were completed if not updated on Resident 2's ISP or in the provider's task care report. Administrator A stated staff completed frequent checks, but it was all verbally between staff. At 12:23 PM, Surveyor asked Administrator A why Resident 2's level of supervision was not increased after several falls including interventions recommended by hospice. Administrator A reported bedrails would have been a restraint and a bed alarm would have just startled Resident 2. Administrator A acknowledged Resident 2's level of supervision was not increased after his/her falls including on 02/14/2025. At 1:30 PM, Surveyor noted Resident 2's ISP indicated frequent checks for his/her fall risk, but did not include details on how frequent these checks were supposed to be completed. Administrator A acknowledged Resident 2's ISP was not updated to include hourly checks and the provider did not have evidence of any new interventions that were implemented to keep Resident 2 safe after several falls. Administrator A stated s/he learned a lot after Resident 2's last 2 falls and updated our policy to include even if on hospice if a resident hits their head, they will be sent to the ER.

On 12/17/2025 at 1:36 PM, Surveyor interviewed Family Member J. Family Member J reported Resident 2's family asked the facility for more interventions to be added due to his/her fall risk, but was always told "no" by hospice because the facility did not allow them.

On 12/23/2025 at 1:41 PM, Surveyor interviewed Hospice Nurse I. Surveyor shared that s/he

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N 426	Continued From page 21 reviewed hospice notes from 01/08/2025 to 02/15/2025 and saw many entries about hospice offering interventions to mitigate Resident 2's fall risk without the facility implementing any of them. Hospice Nurse I acknowledged hospice offered interventions and educated the staff on doing 1 hour checks due to Resident 2's fall risk, but was told by the provider bed rails were against regulations and bed alarms were against their policy. Hospice Nurse I reported s/he was aware the facility was doing frequent checks, but did not know how frequent they were completed and never saw any documentation indicating staff completed frequent or hourly checks.	N 426		