STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510387	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LACROSSE AL	3141 E AVE SOUTH LA CROSSE, WI 54601

(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 03/04/2026, Surveyors conducted 8 complaint investigations at Brookdale Lacrosse AL. Data collection continued through 03/16/2026. Four of 8 complaints were substantiated. Five deficiencies were identified. One of 5 deficiencies was a repeat violation. See Statement of Deficiency HZDD11, dated 08/09/2024. Census: 28	N 000		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure agency staff received orientation training prior to performing job duties. Findings include:	N 230		

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

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N 230	Continued From page 1 The definition of "employee" under DHS 83.02(22) states, "Employee" means any person who works for a CBRF (community based residential facility) or for an entity that is affiliated with the CBRF, or that is under contract to the CBRF, who is under direct control of the CBRF or corporation affiliated with the CBRF and who receives compensation subject to state and federal employee withholding taxes. On 03/04/2026, Surveyor requested review of the staff schedule for actual hours worked for 2026. Surveyor reviewed the schedule for January 2026 provided by Administrator A. Seventy shifts were covered by agency employees, with some employees labeled as "MT" (med tech). At approximately 12:45 PM, Surveyor interviewed Nurse C about agency staff training. Nurse C stated agency staff were given a tour of the building and shown where to find care plans, and how to contact the nurse on duty. Nurse C stated s/he did not believe additional training was provided for agency staff responsible for passing medications. At approximately 1:50 PM, Surveyor asked Administrator A if orientation training was documented for agency staff for the following orientation requirements: (1) Job responsibilities. (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property. (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible. (4) Emergency and disaster plan and evacuation procedures under s. DHS 83.47 (2).	N 230		

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N 230	Continued From page 2 (5) CBRF policies and procedures. (6) Recognizing and responding to resident changes of condition. Administrator A informed Surveyor there was no documentation of orientation training available for agency staff as they did not maintain files on-site for agency staff.	N 230		
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: Based on record review and interview, the provider did not ensure residents received all medications in the dosages and at intervals prescribed by a practitioner. Resident 1 did not receive his/her scheduled pain medication between 01/13/2026 and 01/18/2026. Resident 2 did not receive his/her scheduled heart medications between 12/12/2025 and 01/08/2026. Resident 3 did not receive his/her scheduled heart medication in August 2025 and scheduled antibiotic in December 2025. Resident 4 did not receive 117 doses of medication between January 2026 and March	N 352		

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N 352	Continued From page 3 2026. This is a repeat deficiency. See Statement of Deficiency (SOD) HZDD11, dated 08/09/2024. Findings include: The provider is licensed to care for 36 residents in the client groups of irreversible dementia/Alzheimer's disease, and advanced aged. On 01/05/2026, 01/26/2026, 02/16/2026, and 02/20/2026, the department received complaints alleging resident medications were not available to administer. On 01/20/2026, the department received a self-report that read, in part, "On January 16, 2026, it was observed that [Resident 1] did not received [sic] Oxycodone 2.5 mg medication as per physician prescription from January 13, 2026 at 8 p.m. to January 18, 2026 at 11 a.m. Oxycodone omission was due to a delay in pharmacy delivery ...Resident was sent to Gundersen ER (emergency room) for pain control due to community unable to secure timely prescription from the VA Pharmacy." On 01/20/2026, the department received a self-report, that read, in part, "It was observed that [Resident 2] did not received [sic] medication as per physician orders from December 20, 2025 to January 8, 2026 ...[Resident 2] was sent to the ER on January 1, 2026, evaluated and returned to the community without new orders." On 03/04/2026, at approximately 10:00 AM, Surveyor interviewed Administrator A, Regional Nurse (RN) B and Nurse C. When asked about	N 352		

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the current medication systems in place, Nurse C stated in February s/he was starting from scratch. Nurse C stated s/he had investigated multiple medication errors including 1 investigation that was ongoing. When asked about possible contributing factors leading to the medication errors, Nurse C stated the provider had lacked training and RN B came to the facility in October to provide education and remediation. Nurse C stated the provider's use of agency staff may have also been a factor.

Example 1

On 03/04/2026, at approximately 10:30 AM, Surveyor interviewed Administrator A, Regional RN B and Nurse C. When asked about ongoing investigations, Nurse C stated there had been police contact made to the facility to investigate an incident of missing oxycodone. Nurse C stated a refill of the scheduled medication was requested before the weekend because Resident 1 had been running low. It was determined the medication was delivered, but it could not be found. The medications were placed in the narcotic box on a Sunday and were noted missing on Tuesday. It was unknown if they were accounted for on Monday.

Resident 1 was admitted on 01/25/2024 and had multiple diagnoses, including migraine, polyneuropathy, and unspecified osteoarthritis. Resident 1's January 2026 Medication Administration Record (MAR) included the following:

OxyCodone HCl Oral Tablet 5 MG. Give 0.5 tablet by mouth three times a day for pain. On 01/13/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/17/2026, and 01/18/2026, there was a "20"

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code entered in the designated spaces. The key code on the MAR identified 20 as meaning, "Medication/Treatment Not Available/Pharmacy Action."

Example 2

On 03/04/2026, at approximately 11:00 AM, Surveyor interviewed Resident 2. Resident 2 stated the provider sent him/her to the hospital because they did not have his/her medication. Resident 2 stated s/he was told by the doctor Resident 2's heart had stopped twice when Resident 2 was in the hospital. Resident 2 stated s/he was later told s/he did not receive his/her medication for 9 days.

Resident 2 was admitted on 05/31/2023 and had multiple diagnoses, including chronic atrial fibrillation and essential hypertension. Resident 2's December 2025 MAR included the following:

Amlodipine Besylate Tablet. 2.5 MG. Give 1 tablet by mouth one time a day related to essential (primary) hypertension. On 12/12/2025 through 12/31/2025, there was a "20" code entered in the designated spaces. The key code on the MAR identified 20 as meaning, "Medication/Treatment Not Available/Pharmacy Action."

Apixaban Oral Tablet 5 MG. Give 1 tablet by mouth two times a day for [sic] prevent thromboembolism in chronic atrial fibrillation. Between 12/20/2025 and 12/31/2025, there were 20 entries of the code "20" indicating the medication was unavailable. There had been random spaces that were signed off with a check mark indicating it was administered.

Resident 2's January 2026 MAR included the

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N 352	Continued From page 6 following: Amlodipine Besylate Tablet. 2.5 MG. Give 1 tablet by mouth one time a day related to essential (primary) hypertension. Between 01/01/2026 and 01/04/2026, there were 4 entries of the code "20" indicating the medication was unavailable. Apixaban Oral Tablet 5 MG. Give 1 tablet by mouth two times a day for [sic] prevent thromboembolism in chronic atrial fibrillation. Between 01/01/2026 and 01/08/2026, there were 16 entries marked with a "20" indicating the medication was unavailable. Example 3 Resident 3 was admitted on 07/09/2025 and had multiple diagnoses including chronic atrial fibrilation and chronic diastolic heart failure. Resident 3's August 2025 MAR included the following: Diltiazem HCl Oral Table. 120 MG. Give 1 tablet daily by mouth in the afternoon related to chronic diastolic heart failure. Between 08/01/2025 and 08/05/2025, there were 5 entries marked with a "20" indicating the medication was unavailable. Resident 3's August 2025 progress notes included the following: On 08/02/2025, 08/03/2025, and 08/05/2025, it read, "Medication not in inventory." There was not a notation entered on 08/01/2025 or 08/04/2025, to explain the "20" code that was entered. Resident 3's December 2025 MAR included the following:	N 352		

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N 352	Continued From page 7 Bactrim DS Oral Tablet 800-160 MG. Give 1 tablet by mouth 2 times a day for urinary tract infection for 10 administrations until finished. Take 1 tablet by mouth 2 times a day for 5 days. It included a start date of 12/05/2025. Between 12/05/2025 and 12/13/2025, there were 6 entries marked with a "20" indicating the medication was unavailable. There were 10 entries where the medication appeared to be signed as administered. There should have only been 10 entries total in order to comply with the medication order. There were 16 entries for the Bactrim order. Resident 3's December 2025 progress notes included the following: On 12/05/2025: "Hospice was called by family because [Resident 3] was having more hallucinations thinking [s/he] was going to have a baby. [S/he] has been more painful the last couple days. A UA (urine analysis) was gotten by Hospice RN which was positive. Hospice sent orders for Bactrim DS 1 tab BID (twice daily) x5days. MAR was updated." On 12/08/2025, a note indicated the Bactrim was, "on order." On 12/09/2025 and 12/13/2025, it read, "none in medication cart" and was referring to the Bactrim. Example 4 On 03/04/2026 at approximately 11:15 AM, Surveyor interviewed Caregiver G at the medication cart located by the dining room. Surveyor observed a handwritten note on the medication cart that read, "Plaquenil needs to be ordered for [Resident 4]." Surveyor asked Caregiver G if medication was re-ordered timely to ensure medications were administered as	N 352		

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N 352	Continued From page 8	N 352		

prescribed. Caregiver G stated, "I write down anything that needs to be ordered or we're out of and give it to [Health and Wellness Director (HWD) H]. [Resident 4] is out of Plaquenil and [s/he] gets meds through the VA (Veterans Affairs), which can take a while to get once we're out." Caregiver G stated there really was not a formal system to re-order medications and after s/he handed the note to HWD H, s/he was not sure how or if it was tracked. Caregiver G stated s/he did not write progress notes, and charted in the MAR that it is "not available."

Resident 4 was admitted on 12/13/2018 and had multiple diagnoses including essential (primary) hypertension, hyperlipidemia, constipation, dry eye syndrome, rheumatoid arthritis, and glaucoma.

Surveyor reviewed Resident 4's MAR from January to March 2026. The following dates had entries marked with a "20" indicating the medication was unavailable:

-Atorvastatin Calcium Tablet 10MG: 01/17, 02/18 to 02/20, 02/24, 03/02 to 03/04

-Clobetasol Propionate Liquid 0.05%: 01/03, 01/09, 01/12

-Culturelle Capsule: 01/03 to 01/05, 01/07, 01/15, 01/18 to 01/26, 01/30, 01/31, 02/02, 02/04 to 02/05, 02/09 to 02/11, 02/14.

-Eliquis Oral Tablet 5MG: 01/03, 01/09, 01/17, 02/18 to 02/19, 02/25

-Furosemide Oral Tablet 20MG: 01/02, 01/05, 01/06, 01/09

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N 352	Continued From page 9 -Hydrochlorothiazide Tablet 25MG: 01/03, 01/05, 01/06 -Hydroxychloroquine Sulfate Tablet 200MG: 01/01, 01/03, 01/05 -Latanoprost Ophthalmic Solution: 01/14, 01/17, 01/19, 01/21, 01/23, 01/26, 01/30, 02/05, 02/10 to 02/12, 02/18 to 02/20, 02/24, 03/02 to 03/03 -Metoprolol Tartrate Oral Tablet 25MG: 01/17 -Nasacort Allergy: 01/21, 01/23, 01/26, 01/28 to 01/30 -Omeprazole Tablet 20MG: 01/05 to 01/06 -Plaquenil: 02/18 to 02/20, 02/25, 03/02, 03/04 -Polyethylene Glycol: 01/05, 01/06 -Senna S Oral Tablet: 01/01, 01/02, 01/03, 01/05 to 01/09, 02/13 -Ventolin HFA Aerosol Solution: 01/10, 01/11, 01/14, 02/04, 02/05, 02/07 to 02/17 -Vitamin D3 Tablet: 01/01, 01/02, 01/05, 01/06, 01/09, 01/11, 01/12, 01/15 The provider did not ensure residents received all medications in the dosages and at intervals prescribed by a practitioner when Resident 1, Resident 2, Resident 3, and Resident 4's medications were not available or re-ordered timely for staff to administer. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of	N 352		

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N 352	Continued From page 10 Medication Administration	N 352		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 4 had his/her medication administration accurately documented. Findings include: On 03/04/2026, at approximately 11:15 AM, Surveyor interviewed Caregiver G at the medication cart located by the dining room. Surveyor observed a handwritten note on the medication cart that read, "Plaquenil needs to be ordered for [Resident 4]." Surveyor asked Caregiver G if medication was re-ordered timely to ensure medications were administered as prescribed. Caregiver G stated, "I write down anything that needs to be ordered or we're out of and give it to [Health and Wellness Director	N 415		

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(HWD) H]. [Resident 4] is out of Plaquenil and [s/he] gets meds (medications) through the VA (Veterans Affairs), which can take awhile to get once we're out." Caregiver G stated there really was not a formal system to re-order medications and after s/he handed the note to HWD H, s/he was not sure how or if it was tracked. Caregiver G stated s/he did not write progress notes, and charted in the MAR (medication administration record) that it was "not available."

Resident 4 was admitted on 12/13/2018 and had multiple diagnoses including rheumatoid arthritis.

Surveyor reviewed Resident 4's MAR for March 2026 and found the following documentation discrepancy:

-Plaquenil Oral Tablet 200MG: Give 1 tablet by mouth two times a day related to Rheumatoid Arthritis. The MAR documented the medication was not available at 8:00 PM on 03/02/2026, was given at 8:00 AM and 8:00 PM on 03/03/2026, and was not available at 8:00 AM on 03/04/2026, the date of survey.

At 3:05 PM, Surveyor interviewed Caregiver I, who was responsible for passing medications on the evening shift. Surveyor asked Caregiver I if Resident 4's Plaquenil was available for the PM dose. Caregiver I checked the medication cart and confirmed the medication was not available for the 8:00 AM or 8:00 PM scheduled medication pass. Surveyor reviewed the MAR with Caregiver I and questioned how the 8:00 PM dose was documented not available on 03/02/2026 but given at 8:00 AM and 8:00 PM on 03/03/2026. Caregiver I stated, "I'm sure staff probably just checked it off as administered because it isn't here."

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N 415	Continued From page 12 Caregiver I then checked the medication cart and the medication storage area and could not locate Resident 4's scheduled Plaquenil. Caregiver I stated there was not a formal process or communication on how or when medications were re-ordered for Resident 4's medications. Caregiver I stated Resident 4 received medications from the VA and HWD H was responsible for re-ordering medications from the VA. Caregiver I stated s/he would write HWD H a "sticky note" and gave it to him/her to re-order. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 415		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in	N 454		

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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
N 454	Continued From page 13	N 454		

condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x)

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	510387	A. BUILDING: _____ B. WING _____	C 03/16/2026

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N 454	Continued From page 14 Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident record was maintained for 1 of 4 resident records reviewed. Resident 3's record did not include documentation of his/her activated power of attorney for healthcare (POAHC.) Findings include: On 02/16/2026, the department received a complaint alleging resident POAHC's were not notified of resident falls and emergency room (ER) visits. On 03/04/2026, at 1:15 PM, Surveyor reviewed Resident 3's records. Resident 3 was admitted on 07/09/2025. Resident 3's admission agreement was signed by Resident 3 and the provider's agent on 06/30/2025. The space for legal decision maker signature was blank. Resident 3's Individual Service Plan (ISP), dated 08/19/2025, did not identify Resident 3 had an activated POAHC. Resident 3's facility face sheet included multiple emergency contacts but did not identify an activated POAHC. On 03/05/2026, at approximately 12:45 PM, Surveyors interviewed Administrator A, Regional Nurse (RN) B, and Nurse C via phone. When asked to clarify if Resident 3 had an activated POAHC and who that person was, Administrator A stated s/he had to look in the resident record to	N 454		

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N 454	Continued From page 15 clarify. Administrator A could not confirm the information during the call. At 1:24 PM, Surveyor sent Administrator A an email with a written request to verify Resident 3's POAHC information. At 4:53 PM, Surveyor received an email from Administrator A including an attachment titled, "State Files 3.5.2026." The email and attachment did not include reference to Surveyor's request for Resident 3's POAHC information. 03/12/2026, at approximately 12:20 PM, Surveyor interviewed Hospice Nurse (HN) D. HN D stated his/her agency served Resident 3 and they had Family Member (FM) E listed as Resident 3's activated POAHC. On 03/16/2026, at approximately 10:35 AM, Surveyor interviewed Family Member (FM) F. FM F stated FM E was Resident 3's activated POAHC. Resident 3's spouse was originally the activated POAHC but s/he had relinquished those responsibilities and identified FM E as the activated POAHC on 06/29/2025. As of 03/16/2026, at 2:34 PM, Surveyors had not received clarification from the provider regarding Resident 3's POAHC. Cross Reference: Y3244 DHS 50.09(1)(L) Care	N 454		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as	Y3244		

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Y3244	Continued From page 16 provided in sub. (5), have the right to (I) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3 received adequate and appropriate care within the capacity of the facility related to transfer assistance and hospice coordination. Findings include: On 02/16/2026, the department received a complaint alleging staff did not meet resident care needs. On 03/04/2026, at approximately 1:00 PM, Surveyor interviewed Regional Nurse (RN) B and Nurse C. When asked about the provider's fall protocols for residents receiving hospice services, RN B stated if it was a medical issue, staff would call hospice. If a resident was bleeding, staff would call 911. Nurse C stated Resident 3 was sent to the emergency room (ER) and s/he was not sure why. Resident 3 was	Y3244		

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Y3244	Continued From page 17	Y3244		

receiving hospice services. RN B stated staff called 911 for lift assistance to get Resident 3 off the floor after a fall and they did not have a Hoyer lift. Nurse C stated the medical responder informed Nurse C they would not offer that type of support unless they were transporting a resident to the ER because they could not bill for the visit otherwise. RN B stated staff did not physically lift residents off the floor, and they called 911 for lift assistance for the safety of the residents and staff.

At 1:15 PM, Surveyor reviewed Resident 3's records.

Resident 3 was admitted on 07/09/2025. Resident 3's Individual Service Plan (ISP), dated 08/19/2025, indicated Resident 3 required a 2-person assist for transferring during all transfers. The ISP indicated Resident 3 required the use of a mechanical lift during all transfers. Under an "Escort and Mobility" section, it included a "Universal Fall Precautions for Brookdale Residents: (applies to ALL Brookdale Residents)." Under a "Service Coordination" section, it indicated Resident 3 received hospice services. Under an "Outcome/Goal" section, it read, "Resident's non-Brookdale service coordination needs will be met. Resident will have collaborative efforts on their behalf with supportive services such as hospice, home health and therapy." The ISP did not include directions to immediately notify Resident 3's hospice agency in the event of a fall.

Resident 3's admission agreement, signed on 06/30/2025, included a "Supplemental Services Fee" of $1715. The section stated, "This fee accounts for staff attention to or physical assistance with ...a second person or mechanical

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Y3244	Continued From page 18 lift to help with transfers ..." A document titled, "Hospice Admission Orders For Facility," dated 08/14/2025, included the following: 1. Admit to Gundersen Hospice. Call [Phone Number] for all care conferences, symptom needs, falls, change in status, medication needs, or changes, and at time of death. 2. Call Gundersen Hospice at [Phone Number] before activating any facility standing orders. At 1:46 PM, Surveyor interviewed Administrator A. When asked how staff supported resident falls, Administrator A stated they did not have lifts. Administrator A stated a resident should be assessed after a fall, and if they were safe to get up, staff should get them up off the floor. Surveyor reviewed the provider's fall management policy which included the following: "A fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with, or without injury." It included the following first step: a. Assist the resident and provide first aid or call 911 as indicated and follow the directions of the 911 operator. At 2:16 PM, Surveyor interviewed Administrator A regarding the fall policy. Administrator A stated the fall protocol would not change if a resident was receiving hospice services. At 2:40 PM, Surveyor interviewed Nurse C regarding fall policies and procedures. When asked about Resident 3's fall resulting in an ER visit, Nurse C allowed Surveyor to review an internal incident report dated 07/09/2025. The report indicated paramedics were called to assist	Y3244		

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Resident 3 off the floor. Nurse C stated they usually called hospice in the event of a fall before 911. When asked if it was the policy to call hospice first before 911 for residents receiving hospice services, Nurse C stated it was. Nurse C stated Resident 3 had other falls in the system including 2 falls on 08/05/2025 and another on 09/07/2025. Surveyor noted Administrator A and Nurse C had conflicting responses regarding fall protocols for hospice residents.

On 03/12/2026, at approximately 12:20 PM, Surveyor interviewed Hospice Nurse (HN) D via phone. HN D confirmed his/her agency served Resident 3. HN D reviewed the agency notes for Resident 3. On 08/21/2025, at 6:58 AM, HN D stated they received a call from the provider stating Resident 3 had fallen. Resident 3 was observed during rounds at 11:30 PM the night before, and was found at 1:00 AM face down, on the floor, between his/her bed and dresser. Staff noted an abrasion to Resident 3's left elbow and left knee. The facility staff called 911 for lift assistance without calling the hospice agency. HN D stated the emergency medical technicians (EMT) transferred Resident 3 to the ER for evaluation. HN D stated the visit would not be covered by hospice. HN D stated if the provider had called the hospice agency, the hospice nurse would have assessed Resident 3. HN D stated if medical evaluation was deemed necessary by hospice, the agency would have paid for the ER visit. HN D stated the ER conducted labs and x-rays with no findings. Resident 3 was transferred back to the facility via non-emergent ambulance. HN D stated Resident 3's activated power of attorney for healthcare (POAHC) was not notified. HN D stated a care conference was arranged to include family and staff to discuss a plan to prevent ER visits after a fall that resulted

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Y3244	Continued From page 20	Y3244		

in unnecessary work-up and interventions that negatively affected the resident and his/her care. The hospice nurse left a message for staff to reinforce the plan to call hospice after a fall to avoid sending residents to the ER unless advised by hospice. The hospice nurse also reinforced the importance of calling the POAHC before any transfer. Surveyor noted the prior interview with Nurse C in which Nurse C showed documentation to reflect Resident 3's falls that were entered into the provider's system. Nurse C did not identify Resident 3 had a fall on 08/21/2025 resulting in an ER visit.

On 03/16/2026, at approximately 10:25 AM, Surveyor interviewed Family Member (FM) F via phone. FM F stated Resident 3 had fallen on the day s/he moved to the facility and the provider contacted EMTs for lift assistance. FM F stated Resident 3 had fallen out of bed 3 to 4 times and the provider contacted EMTs for lift assistance each time.

The provider did not ensure Resident 3 received adequate and appropriate care within the capacity of the facility when the provider relied on EMTs to assist with Resident 3's transfers. Resident 3 had been paying a supplemental fee for 2-person assistance with all transfers. The provider did not follow Resident 3's hospice orders and sent Resident 3 to the ER without a hospice assessment. Resident 3 was described as having unnecessary interventions that negatively impacted his/her care.

Cross Reference:
N0454 DHS 83.42(1) Resident Record Maintained