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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 000	Initial Comments On 02/06/2024, with information gathered through 02/08/2024, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey, complaint investigation, and self-report review of Sunrise Meadows Senior Living located at 2800 North Calhoun Road in Brookfield, WI. Two citations of noncompliance were issued. The complaint was unsubstantiated. Census: 26	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: Based on observation, interview, and record review, the provider did not ensure Resident 2, Resident 3, and Resident 4 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 2 did not receive an eye drop medication, as prescribed. Resident 3 and Resident 4 did not receive bowel medication, powdered, as prescribed. The findings include:	N 352		

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

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N 352	Continued From page 1 Example 1: Resident 2's olopatadine eye drops, allergy medication On 02/06/2024 at approximately 12:00 P.M., Surveyor conducted an interview with Director A including observations of the facility's medication cart located in the facility's "back" medication room. Surveyor observed Director A remove a 2.5 milliliter container of olopatadine eye drops labeled with Resident 2's name from the medication cart. Director A told Surveyor this was the only available container of Resident 2's olopatadine eye drops. Surveyor observed the pharmacy label affixed to the container included, "Instill 1 drop in affected eye(s) in the morning" and included the date dispensed by the pharmacy to the facility, "12/02/2023." The date the container was opened was documented, "12/02/2023." Director A told Surveyor the container "felt empty to him/her" as Surveyor observed Director A shake the container in his/her hand. Surveyor observed Director A attempt to dispense a drop of the medication from the container without success as Director A said, the container "appears dry." On 02/08/2024 at 12:53 P.M., Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D told Surveyor a 2.5 milliliter container of Resident 2's olopatadine eye drops was delivered to the facility on 12/02/2023. Pharmacy Staff D told Surveyor the container included a 25 day supply of medication. As of 02/06/2024, 66 days had passed since Resident 2's current container of olopatadine eye drops was dispensed to the facility and opened for administration. On 02/06/2024 at 12:55 P.M., Caregiver C told Surveyor Resident 2's olopatadine eye drops	N 352		

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were to be administered to Resident 2 every day during the morning medication pass. Caregiver C told Surveyor s/he did not know which of Resident 2's eyes were "affected" and needed the medication administered as directed on the pharmacy label. Caregiver C told Surveyor Resident 2 did not refuse medication administration.

On 02/06/2024, Surveyor reviewed Resident 2's record, as provided by Director A and Facility Nurse B. Resident 2 was admitted to the facility on 10/30/2023 with diagnoses including dementia. Resident 2's individual service plan (ISP) dated 10/30/2023 included, "Staff performs medication administration" and "Facility orders medications from pharmacy."
Resident 2's practitioner's orders dated 10/26/2023 included, "Olopatadine 0.2 % eye drops...instill 1 drop into affected eye every day..."
Resident 2's December 2023 medication administration record (MAR) included an order for Resident 2's olopatadine eye drops to be administered, "Instill 1 drop in affected eye(s) in the morning (indications for use: itchy eyes)."
From 12/01/2023 through 12/22/2023, caregivers documented daily administration of olopatadine without identifying into which of Resident 2's eyes or both the medication was administered. On 12/23/2023, Resident 2's December 2023 MAR included a change of indication/reason for Resident 2's olopatadine eye drops to be administered, "Instill 1 drop in affected eye(s) in the morning (indications for use: glaucoma)."
From 12/23/2023 through 12/31/2023, caregivers documented daily administration of olopatadine without identifying into which of Resident 2's eyes or both the medication was administered.
Resident 2's January 2024 and February 2024 MARs included an order for Resident 2's

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olopatadine eye drops to be administered, "Instill 1 drop in affected eye(s) in the morning (indications for use: glaucoma)." From 01/01/2024 through 02/06/2024, caregivers documented daily administration of olopatadine without identifying into which of Resident 2's eyes or both the medication was administered.

On 02/06/2024 at 4:12 P.M., Facility Nurse B told Surveyor s/he called the pharmacy on this date and was told Resident 2's olopatadine eye drop dose should be administered to whichever of Resident 2's eyes looks red. Facility Nurse B told Surveyor s/he would clarify the order with Resident 2's practitioner as soon as possible.

On 02/08/2024 at 2:05 P.M., Surveyor conducted an interview with Director A and Facility Nurse B. Facility Nurse B told Surveyor s/he had not received a response from Resident 2's practitioner identifying which eye or both eyes Resident 2's olopatadine eye drop medication should be administered. Director A told Surveyor a new container of Resident 2's olopatadine eye drop medication was in the "back cart" and s/he would ensure the clarification of Resident 2's eye drop prescription was implemented when received.

Example 2: Resident 3's prescribed polyethylene glycol (bowel medication, powdered)

On 02/06/2024 at approximately 12:00 P.M., Surveyor conducted an interview with Director A including observations of the facility's medication cart located in the facility's "back" medication room. Surveyor observed Director A remove a container of polyethylene glycol labeled with Resident 3's name from the medication cart. Surveyor observed the manufacturer's label

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included, "30 once-daily doses." Surveyor observed the pharmacy label affixed to the container included, "Take 17 gm [grams] (1 capful) dissolved in 8 oz [ounces] by mouth in the morning ([related to] constipation)" and included the date dispensed by the pharmacy to the facility, "11/22/2023." Surveyor observed Director A open Resident 3's container of polyethylene glycol and place it on top of the medication cart. Surveyor observed the container was approximately one half full with approximately 15 doses having been removed from the container. Director A verbally agreed to the amount remaining in the container. Director A told Surveyor it was evident Resident 3's polyethylene glycol was not being administered daily as prescribed. (See photo #1)

On 02/08/2024 at 12:53 P.M., Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D told Surveyor one container of polyethylene glycol, as prescribed, was delivered to the facility from the pharmacy on 11/22/2023. Pharmacy Staff D said this was the only container of polyethylene glycol dispensed to the facility for Resident 3 and refills were not delivered to the facility on an automatic refill cycle. Pharmacy Staff D said the facility staff would need to call the pharmacy for a refill of this medication.
As of 02/06/2024, 76 days had passed since Resident 3's current container of polyethylene glycol was dispensed to the facility.

On 02/06/2024 at 1:00 P.M., Caregiver C told Surveyor Resident 3's polyethylene glycol was to be administered to Resident 3 every day during the morning medication pass. Caregiver C told Surveyor s/he administered polyethylene glycol during this morning's medication pass.

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N 352	Continued From page 5 On 02/06/2024, Surveyor reviewed Resident 3's record, as provided by Director A and Facility Nurse B. Resident 3 was admitted to the facility on 11/09/2023 with diagnoses including constipation and "need for assistance with personal care." Resident 3's individual service plan (ISP) dated 11/09/2023 included, "Staff performs medication administration" and "Facility orders medications from pharmacy." Resident 3's ISP included, "Incontinent of bowel, requires [assistance] from staff." Resident 3's practitioner's orders dated 11/21/2023 included, "Miralax [polyethylene glycol] 17 gms po [by mouth] daily." Resident 3's November 2023, December 2023, January 2024, and February 2024 MARs included documentation of administration of Resident 3's polyethylene glycol, as prescribed, daily from 11/23/2023 through 02/06/2024. Example 3: Resident 4's prescribed polyethylene glycol (bowel medication, powdered) On 02/06/2024 at approximately 12:00 P.M., Surveyor conducted an interview with Director A including observations of the facility's medication cart located in the facility's "back" medication room. Surveyor observed Director A removed two containers of polyethylene glycol labeled with Resident 4's name from the medication cart. Surveyor observed the manufacturer's label included, "30 once-daily doses" on each container. Surveyor observed the pharmacy label affixed to one container included, "Take 17 gm [grams] (1 capful) dissolved in 8 oz [ounces] by mouth 2 times a day ([related to] constipation)" and included the date dispensed by the pharmacy to the facility, "12/14/2023." Surveyor held the container level up to the light and observed the container was approximately one quarter full of	N 352		

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the medication. Director A verbally agreed to the amount remaining in the container. Director A told Surveyor it was apparent Resident 4's polyethylene glycol was not being administered twice daily as prescribed. (See photos #2 and #3) Based on twice daily doses, this container would have been empty by approximately 12/31/2023 if administered as prescribed. Director A said s/he thought Resident 4's prescription had been changed from twice daily to once daily.
Surveyor observed the pharmacy label affixed to Resident 4's second container of polyethylene glycol included, "Take 17 gm [grams] (1 capful) dissolved in 8 oz [ounces] by mouth in the morning ([related to] constipation)" and included the date dispensed by the pharmacy to the facility, "01/04/2024." Surveyor held the container level up to the light and observed the container was practically full of the medication. Director A verbally agreed to the amount remaining in the container. Director A told Surveyor it was apparent Resident 4's polyethylene glycol was not being administered daily as prescribed since the prescription changed. (See photo #4) Based on a daily dose, this container would have been empty by approximately 02/03/2024 if administered as prescribed.

On 02/08/2024 at 12:53 P.M., Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D told Surveyor one container of polyethylene glycol, as prescribed, was dispensed to the facility from the pharmacy on 12/15/2023. Pharmacy Staff D said the second container of polyethylene glycol was dispensed to the facility from the pharmacy on 01/04/2024 after the prescription changed from twice daily to daily on 01/03/2024. Pharmacy Staff D said the facility staff would need to call the pharmacy for a refill of

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this medication.

On 02/06/2024, Surveyor reviewed Resident 4's record, as provided by Director A and Facility Nurse B. Resident 4 was admitted to the facility on 12/15/2023 with diagnoses including dementia and constipation. Resident 4's individual service plan (ISP) dated 12/15/2023 included, "Staff performs medication administration." Resident 4's ISP included, "Incontinent of bowel, requires [assistance] from staff."
Resident 4's practitioner's orders dated 12/08/2023 included polyethylene glycol to be administered, "17 gram [sic] by mouth every morning and at bedtime for constipation."
Resident 4's December 2023 and January 2024 MARs included documentation of administration of Resident 4's polyethylene glycol, as prescribed, twice a day from 12/15/2023 through 01/04/2024, with the exception of 2 missed doses.
Resident 4's January 2024 and February MARs included an order for and document of administration of Resident 4's polyethylene glycol to be administered daily from 01/05/2024 through 02/06/2024 with no missed doses.

On 02/07/2024 at 1:03 P.M., Surveyor received an email from Facility Nurse B including, "Unfortunately, the order pharmacy sent was for the wrong resident. I [Facility Nurse B] am unable to provide the Miralax [polyethylene glycol] order at the this time..."

On 02/08/2024 at 2:05 P.M., Surveyor conducted an interview with Director A and Facility Nurse B. Surveyor asked Facility Nurse B to clarify the resident s/he was addressing within his/her email on 02/07/2024. Facility Nurse B told Surveyor s/he was addressing Resident 4's polyethylene glycol order change from twice daily to once daily.

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N 352	Continued From page 8 Facility Nurse B told Surveyor s/he had not yet received the order for Resident 4's current dose of polyethylene glycol, as requested. Summary: The provider did not ensure Resident 2, Resident 3, and Resident 4 received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	N 352		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 was transferred while caregivers utilized a mechanical lift resulting in significant injury. On 01/19/2024, Caregiver E and Caregiver F did not ensure Resident 1's a strap/loop of Resident 1's Hoyer [mechanical lift] sling was correctly hooked onto the Hoyer lift. As a result, Resident	N 425		

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1 fell out of the Hoyer lift sling and struck his/her head on the base of the Hoyer lift causing significant injury including a scalp laceration and multiple rib and spinal fractures. Resident 1 was hospitalized for treatment, including pain management, from 01/19/2024 before being admitted to a skilled nursing facility on 01/26/2024 where Resident 1 remained on 02/08/2024.

The findings were:

On 01/26/2024, the department received a documented self-report from Director A regarding a "fall with significant injury" involving Resident 1, Caregiver E, and Caregiver F. The documentation included the incident occurred on 01/19/2024 at 11:15 A.M. The documentation included, "Per caregivers statement [Resident 1] was being lifted via Hoyer [mechanical lift] from [his/her] bed to [his/her] recliner. While raising the Hoyer and turning [Resident 1] to position, [Caregiver E and Caregiver F] heard a loud pop noise and [Resident 1] fell while in a lifted position. [Caregiver E and Caregiver F] noted [Resident 1] hit [his/her] head on the metal legs of the Hoyer and saw [Resident 1] was bleeding from [his/her head]. 911 was initiated immediately. [Resident 1] obtained a laceration/hematoma to the back of [Resident 1's] head resulting in 6 staples." The documentation included, "[Resident 1] staying at [hospital] for further observation and for IV [intravenous] antibiotics to treat noted UTI [urinary tract infection] associated with indwelling catheter." The documentation included, "[Resident 1's] ISP [individual service plan] has been updated, staff will be educated to double check strap placement prior to lifting resident via Hoyer lift. [Medical equipment company] set up by [Director A] for

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staff education with Hoyer transfers and additional demonstrations/return demonstrations added." The documentation included, "[Resident 1] is a 2-person assist transfer via Hoyer lift."

On 01/26/2024, the department received a documented self-report addendum from Director A regarding Resident 1's incident on 01/19/2024. The documentation included, "On 01/24/2024, [facility] was notified that MRI [magnetic resonance imaging] was complete [sic] through [his/her] on 01/23/2024. [Resident 1] has 4 rib fractures, 4 thoracic spine fractures, and 2 lumbar spine fractures." The documentation included, "[Resident 1] is [sic] remains at hospital for pain control."

On 02/06/2024 at 10:25 A.M., Surveyor conducted an interview with Caregiver J. Caregiver J told Surveyor s/he was hired at the facility in October 2023 and was shown by another caregiver how to use mechanical lifts, including a Hoyer lift, following his/her employment. Caregiver J told Surveyor s/he did not receive mechanical lift training by facility management until after the incident involving Resident 1 on 01/19/2024.

On 02/06/2024 at 1:05 P.M., Surveyor conducted an interview with Caregiver C. Caregiver C told Surveyor s/he was hired at the facility on 12/11/2023 and was shown by another caregiver how to use the Hoyer lift for Resident 1. Caregiver C told Surveyor s/he did not receive "official" training regarding mechanical lifts by the facility until after the incident involving Resident 1 on 01/19/2024. Caregiver C said the "true" training included return demonstrations using the mechanical lifts.

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N 425	Continued From page 11 On 02/06/2024 at 1:11 P.M., Surveyor conducted an interview with Resident 5. Resident 5 told Surveyor s/he was in Resident 1's and Resident 5's shared room at the time of the incident on 01/19/2024. Resident 5 told Surveyor 2 caregivers were utilizing a Hoyer lift to transfer Resident 1 when s/he heard a caregiver yell out. Resident 5 said s/he turned to see Resident 1 coming out of the sling and saw Resident 1's head hit the base of the Hoyer lift. Resident 5 said s/he saw a lot of blood coming out from Resident 1's head. Resident 5 said s/he could tell Resident 1 was in significant pain by the time the ambulance arrived. Resident 5 said s/he went to visit Resident 1 at the skilled nursing facility on 02/07/2024 and Resident 1 was not able to use his/her arms to feed self. Resident 5 told Surveyor s/he was informed one of the Hoyer lift sling straps was not attached to the lift correctly. On 02/06/2024, Director A, Facility Nurse B, and Surveyor reviewed caregiver files including Caregiver E's and Caregiver F's employee files. Caregiver E was hired at the facility on 10/11/2023 and received mechanical lift training on 10/27/2023 during orientation training. Facility Nurse B reviewed the documentation of mechanical lift training and told Surveyor another team member/caregiver provided Caregiver E with the training. Facility Nurse B told Surveyor s/he recalled Caregiver E verbalizing feeling competent with use of mechanical lifts but was not sure Caregiver E was observed using mechanical lifts during orientation training. Caregiver F was hired at the facility on 03/16/2023 and Caregiver F's mechanical lift training included, "N/A [not applicable]." Facility Nurse B reviewed the documentation regarding mechanical lift training and told Surveyor Caregiver F verbalized being able to use	N 425		

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mechanical lifts when Caregiver F was interviewed about Resident 1's incident on 01/19/2024 but the facility did not have any documentation of Caregiver F's training regarding mechanical lifts.

On 01/26/2024, the department documentation of the facility investigation report of Resident 1's incident on 01/19/2024. The documentation included, "An investigation was conducted and determined that while staff had received training in regards to transfers and mechanical lifts, this training was not followed appropriately. Staff involved [Caregiver E and Caregiver F] were termed [terminated] and reported to DHS [Department of Health Services] DQA [Division of Quality Assurance] for caregiver misconduct accordingly."
The documentation included, "Upon investigation, it was determined that staff [Caregiver E and Caregiver F] did not appropriately loop the hook for the sling onto the Hoyer appropriately and instead rested it on top of the bar. This resulted in the loop sliding off of the Hoyer and the subsequent fall that occurred. Staff education was established at hire regarding Hoyer transfers and the two staff [Caregiver E and Caregiver F] providing the transfer the day of the incident had experience providing Hoyer transfers in their past. All staff involved were interviewed and information gathered. In interviewing [Caregiver F], [s/he] notes that [s/he] did not provide immediate treatment and apply pressure to [Resident 1's] scalp. [Caregiver F] was unable to determine the exact placement of [Resident 1] during the incident and afterwards. [Caregiver F] reported the loop that came loose was near [Resident 1's] foot when [Director A] who assisted after the event observed the loose loop to be near [Resident 1's] L [left] shoulder which is more

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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
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consistent with [Resident 1's] body placement on the floor and injuries sustained as a result of [his/her] fall. It was determined that [Resident 1] was too high in the Hoyer as well which is a contributing factor to [his/her] injuries as the impact would have been greater from a higher height. [Caregiver F] was unable to consistently recall the placement of the wheelchair and Hoyer in relation to [Resident 1's] body."
The documentation included, "[Caregiver E] was interviewed, [s/he] was the other caregiver involved. [Caregiver E] was controlling the Hoyer at the time of the fall. Per [Caregiver E], the staff checked the Hoyer and [Resident 1] spun after the loop came loose as [s/he] was falling to the ground. [Caregiver E] states that [Caregiver F] was turning [Resident 1] in the Hoyer when the loop came loose. [Caregiver F] did not recall this detail. [Caregiver E] was able to validate the training [s/he] received regarding Hoyer transfers. Neither caregiver was clear on exactly what had occurred. While reviewing the gathered information throughout the investigation, it was determined that both caregivers did not follow the training provided and the necessary steps to ensure resident safety resulting in significant injury. As a result of this gross negligence [Caregiver E and Caregiver F] have been termed [terminated] and subsequently reported for caregiver misconduct."
The documentation included, "Facility provided additional Hoyer training with all staff who provide care and assistance to staff [sic] with Hoyer lifts. Hands on training provided with staff including having staff utilize sit to stand lift. Staff signed off noting use of Hoyer and sit to stand [lifts]."
On 02/06/2024 at 5:05 P.M., Surveyor observed Resident 1's Hoyer lift used during the incident on 01/19/2024 and as Director A explained how the incident occurred based on his/her documented

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investigation. Director A's demonstration included how the lift sling strap/loop was not appropriately hooked onto the Hoyer lift bar and the location of where Resident 1's head made contact with the base of the Hoyer lift. (See photos #5, #6, #7, #8, and #9)

On 02/06/2024 at 3:45 P.M., Director A told Surveyor all current staff completed hands-on, mechanical lift "refresher" training, as mentioned in the facility's investigation documentation, on 01/25/2024. Director A and Surveyor reviewed documentation of the "refresher" training, dated 01/25/2024.

On 02/06/2024 at 3:22 P.M. and 4:30 P.M., Surveyor conducted an interview with Director A. Director A told Surveyor s/he initially "wrote both [Caregiver E and Caregiver F] up with a warning before Director A realized the extent of Resident 1's injuries resulting from the incident on 01/19/2024 and before s/he concluded his/her investigation into the incident. Director A told Surveyor s/he began an investigation on 01/19/2024 into the incident involving Resident 1. Director A told Surveyor Caregiver E and Caregiver F told him/her they thought everything was okay when they started to lift Resident 1 in the Hoyer lift sling. Director A told Surveyor Caregiver E and Caregiver F told Director A they tugged on the sling straps to check correct placement. Director A told Surveyor if Caregiver E and F checked the sling straps they would have noticed one of the straps was not placed correctly and hooked onto the lift bar. Director A told Surveyor Caregiver E and Caregiver F continued to work following the incident and during the following week. Director A and Surveyor reviewed the facility's January 2024 staff schedule. Caregiver E worked on 01/22, 01/23,

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and 01/24/2024 from 6:00 A.M. until 2:00 P.M. and Caregiver F worked on 01/20, 01/21, 01/23, 01/24, and 01/25/2024 from 7:00 A.M. until 1:00 P.M. Director A told Surveyor Caregiver E and Caregiver F were terminated from employment on 01/26/2024 and Director A submitted a misconduct report to the department for both Caregiver E and Caregiver F on 01/26/2024. Director A told Surveyor a durable medical equipment [DME] company will be coming to the facility in the near future to review every aspect of the mechanical lifts with the staff including use, slings, and parts. Director A told Surveyor the facility was also looking into a different type of sling to be used with the Hoyer lifts.

On 02/06/2024, Surveyor reviewed Resident 1's record as provided by Director A and Facility Nurse B. Resident 1 was admitted to the facility on 12/14/2024 with diagnoses including diabetes, dementia, anxiety disorder, chronic pain, spinal stenosis [narrowing], cervical [neck region] disc disorder, and unsteadiness on feet. Resident 1's ISP dated 12/14/2024 included, "I [Resident 1] prefer to sleep in recliner then require to be transferred to bed for changing. I [Resident 1] am not comfortable in the hospital bed due to my chronic back pain and weakness. I [Resident 1] cannot support my own weight and need to be repositioned in my recliner often." Resident 1's ISP included, "Requires assist of 2 for transfers with Hoyer lift..." and "[Resident 1] requires 2 assistance with all transfers, changing of briefs and clothes."

On 02/08/2024 at 9:06 A.M., Surveyor received Resident 1's hospital discharge record from Facility Nurse B. The documentation included Resident 1 was admitted to the hospital on 01/19/2024 and discharged from the hospital on

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01/26/2024. The documentation included, "[Resident 1] was admitted to the hospital due to a scalp laceration and multiple fractures sustained after a fall. [Resident 1] was being moved to [sic] the Hoyer lift at [his/her] facility when [s/he] unexpectedly fell from the Hoyer lift. [Resident 1's] head hit the base of the Hoyer lift in [his/her] back at the floor." The documentation included, "Physical exam was notable for...a scalp laceration that was treated with staples in the emergency department." The documentation included, "[Resident 1] complained of significant pain with any type of movement in the bed." The documentation included, "Subsequent CT [computed tomography] of the thoracic and lumbar spine noted multiple compression fractures (T4, T6, T9, T11, T12 and L1), several transverse process fractures, and rib fractures involving the sixth and seventh posterior ribs on the left and the posterior eighth rib on the right." The documentation included, "[Physician G] recommended conservative management with analgesic [pain] medications as needed." The documentation included, "[Physician I] of the palliative service also evaluated [Resident 1] and had just multiple discussions with [Resident 1's Legal Representative H]. They [Resident 1's Legal Representative H] wish to continue aggressive care at this point in time but will consider transition to hospice in the future depending upon [Resident 1's] clinical course. Anticipate transfer to a skilled nursing facility for subacute rehab [rehabilitation] later today [01/26/2024]."

On 02/08/2024 at 2:05 P.M., Surveyor conducted an interview with Director A and Facility Nurse B. Director A told Surveyor Resident 1 was admitted to a local skilled nursing facility on 01/26/2024. Director A said was informed Resident 1 was sent

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N 425	Continued From page 17 to the hospital for less than 24 hours related to Resident 1's head wound bleeding before returning to the skilled nursing facility where Resident 1 remains as of 02/08/2024. Summary: The provider did not ensure Resident 1 was transferred while caregivers utilized a mechanical lift resulting in significant injury.	N 425		