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 _____	C 02/06/2025

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 02/06/2025, Surveyor conducted a complaint investigation at Sunrise Meadows Senior Living. Two deficiencies were identified. The complaint was substantiated. Census: 44	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the needs, abilities and physical condition of residents was assessed when there was a change in condition for 1 of 1 resident reviewed. Resident 1 did not have an assessment completed after s/he started hospice services. Findings include: On 02/06/2024, Surveyor reviewed Resident 1's	N 381		

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

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N 381	Continued From page 1 record and identified the following: Resident 1 was admitted to the facility on 08/12/2024 with a diagnosis of vascular dementia. Resident 1 received hospice services, before passing away on 11/12/2024. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 1's individual service plan (ISP) dated 08/12/2024 indicated: "Requires physical assistance with activities of daily living, Mental Status: Resident requires additional cueing due to impaired judgement, resident requires additional safety support at night, resident requires additional time/place orientation." The ISP did not address Resident 1 receiving hospice services. Resident 1's progress notes documented: "10/02/2024: Monthly Wellness Note: Outside Service- Badger Cancer: There have been no changes to residents ADLs or care needs in the past month. This resident does not have PRN psychotropic meds ordered. [Resident 1] has received infection monitoring. 10/22/2024: Res' [daughter/son] requested res b/p to be checked due to concern that it may be elevated. Writer checked res b/p which read 172/91 at this time. Call to hospice to notify and res scheduled b/p med given at this time. Hospice informed the writer to check again around 9pm to see if anything further needs to be done. 10/24/2024: Res b/p running pretty high this evening. Cheeked at 7pm reading at 207/97. Blood pressure med given at that time ....Hospice notified at this time." Surveyor reviewed Resident 1's hospice notes dated 09/23/2024-11/12/2024 and identified the following:	N 381		

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N 381	Continued From page 2 -Resident 1 started hospice services on 09/23/2024 and passed away on 11/12/2024. -Hospice made 17 visits to the facility to assess Resident 1 on the following dates: 09/23/2024, 10/15/2024, 10/23/2024, 10/24/2024, 10/25/2024, 10/28/2024 (x2), 11/01/2024, 11/03/2024, 11/04/2024, 11/05/2024, 11/06/2024, 11/08/2024, 11/09/2024, 11/10/2024, 11/11/2024, and 11/12/2024. On 02/06/2025 at 11:33 AM, Surveyor interviewed Hospice Director E regarding Resident 1. Hospice Director E reported Badger hospice only completed nursing visits for Resident 1. Hospice Director E reported after looking over Resident 1's chart, the facility and family made multiple calls to hospice about high blood pressure values and pain management. On 02/06/2025 at 1:58 PM, Surveyor interviewed Administrator A and Market Nurse B in an office at the facility. Surveyor shared earlier in the day s/he had requested any assessments completed for Resident 1 during their admission, but was never given the documentation. Administrator A reviewed Resident 1's chart during the interview and stated s/he was unable to locate a change of condition assessment when Resident 1 started receiving hospice services. Administrator A acknowledged a change of condition assessment should have been completed in September 2024 after Resident 1 started receiving hospice services. Administrator A did not provide an answer to why the requirement was not met.	N 381		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient	N 396		

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N 396	Continued From page 3	N 396		

numbers on a 24-hour basis to meet the needs of the residents.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the facility was staffed to meet the needs of residents. From 11/08/2024-11/09/2024, during the 3rd shift (10pm-6am), the provider did not have a caregiver able to administer medications to Resident 1. At time of incident, Resident 1 was end of life and required pain medications throughout the night.

Findings include:

The provider is licensed to serve up to 52 residents in the client groups of developmentally disabled, irreversible dementia/Alzheimer's, advanced age, and emotionally disturbed/mental illness.

On 11/22/2024, the Department received a complaint alleging concerns the provider did not have a medication passer on the 3rd shift during the first week of November 2024.

On 02/06/2025, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 08/12/2024 with a diagnosis of vascular dementia. Resident 1 was received hospice services, before passing away on 11/12/2024. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 1's individual service plan (ISP) dated 08/12/2024 indicated "staff performs medication administration, administer medications as ordered by MD." Resident 1's physician orders

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N 396	Continued From page 4	N 396		

included: "Hydromorphone 2mg tablet with directions to take 1 tablet by mouth/under tongue every hour as needed for moderate to severe pain. Lorazepam 1mg tablet with directions to take 1 tablet by mouth every hour as needed for restlessness/anxiety end of life." Resident 1's record indicated s/he had increased pain, started using oxygen, and difficulty swallowing on 11/3/24 and 11/4/24.

Resident 1's hospice notes documented: "11/9/24 at 3:18 AM: Spoke to the patients [daughter/son]. [S/he] is very upset about the lack of care [Resident 1] has been receiving from the facility. [S/he] stated that the patient has been waiting 2 hours for pain medications. Spoke to the facility staff, the staff stated they do not have med passers tonight. [S/he] stated [s/he] has tried calling [his/her] boss multiple times tonight and no one is answering. I asked if the staff has access to the pain medications cabinet. The facility staff states that [s/he] has the keys but [s/he] is unable to administer the medication [him/herself]. Will send on call RN to see the patient. Reassured the patient's [daughter/son] that a nurse will be coming to administer the pain medications. Allowed the patient's [daughter/son] to express [his/her] frustrations, and I provided comfort. Patient's [daughter/son] stated that [s/he] has been in contact with the director multiple times about the poor care [his/her] [mother/father] has been getting, [s/he] also stated [s/he] has been in contact with the community care coordinator as well. [S/he] is extremely frustrated.
11/09/2024 at 4:20 AM: Prn visit to check pain management and admin pain medications. Writer got a call from [daughter/son] stating there was no med passer in the building and [Resident 1] needed [his/her] pain medication ...Vitals taken during assessment ...Pain level is 7/10 with

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N 396	Continued From page 5	N 396		

movement and moderate touch. Writer admin 2mg Dilaudid orally by mixing with 2 drops of water admin via syringe to lower gum line ....Writer also performed oral cares and writer provided active listening for [daughter/son] to express [him/herself] and the challenges [s/he] faces with the lack of communication with [him/her] and the facility staff.
11/09/2024 at 10:30 AM: Writer received an update on events from overnight and asked for guidance especially pertaining to med passer, administration not responding, and patient needs not being met ....Writer received a call at 9:51 am from [Administrator A] reporting volume on phone was off and that there would be a med passer on Saturday and Sunday night and [s/he] would also continue to be available if needed."

Surveyor reviewed the provider's staff schedule and timesheets dated 11/01/2024-11/12/2024. Surveyor identified the following concerns:
-11/08/2024-11/09/2024 (10pm-6am): Caregiver C and Caregiver D were present for the whole shift.

A review of the CBRF registry indicated Caregiver C did not have training in medication administration. Caregiver D was on the registry for medication administration.

Caregiver D's RN nursing delegation form was not completed until 11/13/2024.

On 02/06/2025 at 12:30 PM, Surveyor interviewed Administrator A regarding the above date. Administrator A reported the provider normally does not have residents who required medications on the 3rd shift, but if end of life medications were required and staff did not have training, our backup plan required me

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N 396	Continued From page 6 (Administrator A) to be called. Administrator A further reported s/he would come to the facility to administer medications if required. Administrator A stated s/he remembers the night of 11/8/24-11/9/24 and noted s/he forgot to turn their cellphone ringer back on after going to the movies earlier in the evening. Administrator A confirmed Resident 1 had to wait 3 hours before receiving pain medications because the provider did not have a staff available to administer medications. Administrator A reported when waking up in the morning s/he had missed calls from staff and hospice. Administrator A stated s/he followed up with hospice and apologized for not being able to administer Resident 1 medications. Administrator A stated s/he could not remember why staff could not administer medications but would investigate further. On 02/06/2025 at 12:46 PM, Surveyor interviewed Administrator A regarding the above incident. Administrator A confirmed the facility was not staffed with a caregiver able to pass medications on the 3rd shift of 11/08/2024 into 11/09/2024. Administrator A confirmed Caregiver C was not on the CBRF registry for medication administration, but Caregiver D was. Administrator A reported Resident 1's end of life medication required them to be crushed and administered via a syringe. Administrator A reported per the provider's policy medication passers are required to be delegated by the nurse and are not given access to the electronic health record (EHR) until being delegated. Administrator A reported Caregiver D would have not had access to the EHR the night of 11/8-11/9 due to not being delegated.	N 396		