STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

(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 04/30/2025, Surveyor concluded a complaint survey at Brenwood Park Assisted Living. Four deficiencies were identified. One complaint was unsubstantiated. One complaint was substantiated. Census: 41	N 000		
N 354	83.32(3)(j) Rights of Residents: Treatment options In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Treatment options. Participate in the planning of care and treatment, be fully informed of care and treatment options and have the right to refuse any form of care or treatment unless the care or treatment has been ordered by a court. This Rule is not met as evidenced by: Based on record review and interview, the provider did not inform 1 of one resident of his/her care and treatment options upon move in (Resident 2). Resident 2 was not informed that refusal of the providers in-house physician's care and/or treatment, s/he would be responsible for arranging and transporting his/her own outside physician appointments. Resident 2 chose to stay with his/her outside physician. Resident 2 was not fully informed of care and treatment options which resulted in him/her missing a physician's appointment. Findings include:	N 354		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

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N 354	Continued From page 1 Between 04/16/2025 and 04/17/2025, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted to the facility on 11/18/2020, with diagnoses including urinary tract infections, depression, and hemiplegia (paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Resident 2 was his/her own decision maker. Resident 2's most recent assessment in his/her file was dated 05/29/2024. Resident 2's assessment did not indicate who arranged for physician appointments. Resident 2's individualized service plan (ISP), dated 03/25/2025, under transportation, read, "Residents family will provide transportation for medical appointments. Depends on others for transportation." Resident 2's ISP did not indicate who was responsible for monitoring and arranging Resident 2's medical appointments. Resident 2's Admission agreement, dated 11/18/2020, did not indicate who arranged for physician appointments or transport to the appointments. Resident 2 was hospitalized for viral gastroenteritis, severe protein calorie malnutrition and severe dehydration from 01/18/2025 to 01/20/2025. Resident 2's discharge summary, dated 01/20/2025, stated Resident 2 should follow up with his/her primary physician within 1 week. Surveyor reviewed observation notes dated 09/12/2024 to 03/17/2025. Surveyor did not	N 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 354	Continued From page 2 observe documentation that Resident 2 had a follow up appointment with his/her physician one week after his/her hospitalization. Surveyor did not find evidence in Resident 2's file that s/he had a follow-up appointment with his/her primary care physician. On 04/16/2025 at 4:45 p.m., Surveyor interviewed Clinical Director (OD) I. Surveyor requested to see follow-up physician appointment paperwork. OD I stated the provider does not facilitate physician appointments. When residents move in, if they choose to continue with their outside physician, the resident or the family is expected to schedule the physician appointments and transport the resident to the appointments. Surveyor requested to see where that was communicated to and agreed on with the resident. Clinical Director (OD) I stated, "That's a good question. I'm not sure it is in writing. If we were handling physician appointments, we would document that in the progress notes. I do not see anything in there for the week of 01/27/2025 to 01/31/2025." On 04/17/2025 at 9:55 a.m., Surveyor interviewed Managed Care Organization (MCO) Care Manager (CM) H, who confirmed that the provider is all inclusive. CM H stated s/he utilized that provider because they set up and transport to physician appointments and they also have the option of an in-house physician. Surveyor asked CM H if the resident choses to stay with their physician, is the provider still obligated to set up and transport to physician appointments. CM H stated, "Yes. The provider is still responsible for set up and transport to physician appointments."	N 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

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N 381	Continued From page 3	N 381		
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 staff interview, the provider did not assess 1 of 1 resident (Resident 2), upon change in condition. On Resident 2 was not reassessed following an unwitnessed fall resulting in a closed fracture of shaft of left humerus on 11/04/2024. Resident 2 returned to the facility with a splint/sling. Findings include: From 04/16/2025 to 04/17/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the facility on 11/18/2020, with diagnoses including urinary tract infections, depression, and hemiplegia (paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Resident 2 was his/her own decision maker.	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

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N 381	Continued From page 4 -Resident 2's most recent assessment in his/her file was dated 05/29/2024. On 11/04/2024, Resident 2's after visit summary from an emergency room visit stated reason for visit was, "Fall, arm injury. Closed fracture of shaft of left humerus, unspecified fracture morphology, initial encounter." Emergency Room Physician (ERP) F provided instructions on understanding humerus fracture, splint care and discharge instructions. On 04/16/2025 at 1:52 p.m., Surveyor interviewed Caregiver E, who stated Resident 2 already had left side paralysis. After s/he had his/her fall and fractured his/her arm, s/he needed to wear a splint/sling. Resident 2 needed additional assistance with taking splint/sling on and off. Caregiver E emphasized, "Resident 2 needed extra help because s/he was in a lot of pain." On 04/16/2025 at 1:52 p.m., Surveyor interviewed Operations Director (OD) A, who stated Resident 2 had a fall in his/her bathroom and fractured his/her left shoulder. OD A stated, "S/He needed help putting on and taking off his/her splint/sling. Transfers and ADL's (Activities of Daily Living) were different for Resident 2 after the fracture because Caregivers had to be more cautious. Resident 2 was fragile and was a tremendous amount of pain." OD A confirmed Former Clinical Director (FCD) C did not reassess Resident 2 after his/her fall and fractured humerus. On 04/17/2025 at 9:45 a.m., Surveyor interviewed Managed Care Organization (MCO) Care Manager (CM) H, who confirmed that the MCO did do a change in condition assessment after Resident 2 fractured his/her humorous. CM H	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

(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 381	Continued From page 5 stated, "The caregivers had to start assisting with [Resident 2's] arm splint/sling]." Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 381		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's Individual Service Plan (ISP) was implemented for 1 of 1 resident. Resident 1 had a history of falls. Resident 1's call light was on the floor, out of reach. Findings include: On 12/13/2024, the Department received a complaint alleging resident neglect. From 04/16/2025 to 04/17/2025, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted on 03/22/2024, with diagnoses including Parkinson's disease, macular degeneration and osteoarthritis. Resident 1's Health Care Power of Attorney was activated on 10/04/2023. -Resident 1's comprehensive assessment, dated 10/04/2024, identified services needed for mobility. Resident 1's goal was to maintain the ability to ambulate independently. One	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

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N 388	Continued From page 6	N 388		

intervention was to have his/her call light within reach when in his/her room.

-Resident 1's record included an ISP with no signatures of agreement indicating the date the ISP went into effect. The document read, "Mobility. Goal. Resident will maintain ability to propel own wheelchair through the next review. 01/20/25. Resident has been identified as a fall risk. Interventions in place to prevent falls:

On 04/16/2025 at 12:25 p.m., Surveyor observed Resident 1 in his/her apartment. Resident 1 was sitting in his/her chair with feet reclined. Under his/her reclined legs, Surveyor observed his/her call button. It was plugged in the wall on the opposite side of the room and stretched across the floor, under the chair and the button was next to Resident 1's chair under his/her side table.

On 04/16/2025 at 12:28 p.m., Surveyor interviewed Resident 1 who stated if s/he needed help, s/he would push the call button. Surveyor asked where the button was. Resident 1 stated, "I don't know where it is right now."
On 04/16/2025 at 12:35 p.m., Surveyor picked up Resident 1's call button and pushed it. The red light on the wall began to blink. Resident 1 stated, "if I can't get out of this chair, I push this button, it turns on the red light and someone from the outside comes in. If they come right away, it's great. But if they don't come right away, I could die. I've been sitting here since 8:00 this morning."

On 04/16/2025 at 12:41 p.m., Caregiver K entered Resident 1's room and stated, "I've been running around like crazy. I forgot about [Resident 1]." Caregiver K confirmed Resident 1 was supposed to always have call light due to being a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

(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 388	Continued From page 7 fall risk.	N 388		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interviews the provider did not monitor the health of 1 of 1 resident (Resident 2). On 12/14/2024, the provider weighed Resident 2,	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

(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 431	Continued From page 8	N 431		

standing at 152.6 pounds. On 02/14/2025, the provider weighed Resident 2 sitting at 139.4 pounds. There was no evidence Resident 2's physician was called to report weight loss.

From 01/18/2025 to 01/20/2025, Resident 2 was hospitalized for viral gastroenteritis, severe protein calorie malnutrition and severe dehydration. Resident 2's discharge summary, dated 01/20/2025, stated Resident 2 should follow up with his/her primary physician within 1 week. Resident 2's file did not contain evidence that s/he had a follow-up appointment with his/her primary care physician.

Findings include:

Between 04/16/2025 and 04/17/2025, Surveyor reviewed Resident 2's record and identified the following:

Example 1

Resident 2 was admitted to Ascension Hospital from 01/18/2025 to 01/20/2025. The reason for hospitalization listed, "Gastroenteritis, severe protein calorie malnutrition and severe dehydration." Resident 2's after visit summary from hospitalization stated Resident 2's weight was, "149.5 lbs." Follow-up and referral orders stated, "Follow-up in: within 1 week."

On 04/16/2025 at 4:50 p.m., Surveyor interviewed Clinical Director (CD) I, who stated the provider does not facilitate physician appointments. When residents move in, if they choose to continue with their outside physician, family is expected to schedule the physician appointments and transport the resident to the appointments. Surveyor requested to see where that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

(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 431	Continued From page 9	N 431		

communicated to and agreed on with the resident. CD I stated, "That's a good question. I'm not sure it is in writing. If we were handling physician appointments, we would document that in the progress notes. I do not see anything in there for the week of 01/27/2025 to 01/31/2025."

On 04/17/2025 at 9:55 a.m., Surveyor interviewed Managed Care Organization (MCO) Care Manager (CM) H, who stated they were unaware of Resident 2's hospitalization from 01/18/2025 to 01/20/2025. CM H stated, "That is concerning that the provider did not even contact us about him/her being in the hospital. We should have put a bed hold on the apartment. That could have been a big mess for the resident and for them."

Example 2

Resident 2 was admitted to the facility on 11/18/2020, with diagnoses including urinary tract infections, depression, and hemiplegia (paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Resident 2 was his/her own decision maker.

Resident 2's Wisconsin Level of Care Assessment, dated 05/29/2024, stated his/her most recent weight on 06/05/2024 was 152.2 with wheelchair scale. Under nutrition/eating, there was no marked evaluation. Under eating, it read, "Independent."

Resident 2's individualized service plan (ISP), dated 03/25/2025, under nutrition/eating, identified Resident 2 had a regular diet, with thin liquids. Resident 2's goal was to, "Maintain adequate nutritional status as evidenced by maintaining weight. Date initiate: 11/18/2020. Revision on: 08/16/2022." Resident 2 was to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

(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 431	Continued From page 10	N 431		

provided meals, "Three times daily and snacks." Surveyor read, under nutrition/eating, "Assist with cutting foods. Encourage resident to drink fluids of choice." Resident 2 did not sign his/her ISP. Wellness/physical health goal read, "Staff will notify residents [sic] medical practitioner timely if any changes in physical health [sic]."

Surveyor reviewed Resident 2's weight and vital summary report, dated 01/05/2021 to 04/05/2025. The following was identified:
- 10/05/2024, Resident 2 weighed 158.3 pounds (sitting).
- 11/05/2024, Resident 2 weighed 156.6 pounds (sitting).
- 12/05/2024, Resident 2 weighed 152.6 pounds (standing).
- 02/14/2025, Resident 2 weighed 139.4 pounds (sitting).
- 02/14/2025, under, 'Warnings', the weight and vital summary report read, "-10% change [Comparison Weight 10/05/2024, 158.3 lbs (pounds), -11.9%, -18.9% lbs]. -7.5% change [Comparison Weight 12/05/2024, 152.6 lbs, -8.7%, -13.2 lbs].

Surveyor reviewed observation notes dated 09/12/2024 to 03/17/2025. Surveyor did not observe evidence that Resident 2's physician was contacted and consulted regarding Resident 2's weight loss.
According to the Academy of Nutrition and Dietetics (AND), the categories for what is determined as significant versus severe weight loss are correlated with the following intervals:
- 1 month: Significant = 5% / Severe = greater than 5%
- 3 months: Significant = 7.5% / Severe = greater than 7.5%
- 6 months: Significant = 10% / Severe = greater

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	9535 W LOOMIS RD FRANKLIN, WI 53132

(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 431	Continued From page 11	N 431		

than 10%
(Source: Academy of Nutrition and Dietetics, Determining the Severity of Unintended Weight Loss, no date, https://www.andeal.org/files/Docs/ON%20Determining%20Severity%20of%20UWL_07032013.pdf (retrieval date - April 17, 2025).).

On 04/16/2025 at 3:25 p.m., Surveyor interviewed Wellness Coordinator (WC) D and OD A regarding the health monitoring of Resident 2's weight loss and post falls/arm fracture care. WC D stated FCD C was let go a week before Christmas and Former Executive Director (FED) G was let go around the new year. WC D stated, "We have just been trying to catch up and clean up since then." Surveyor asked who was aware of Resident 2's weight loss and if it was it was report to the resident ' s physician. WC D stated, "As of right now, probably no one knows about her weight loss. I know s/he had norovirus and was hospitalized in January."

On 04/16/2025 at 4:45 p.m., Surveyor interviewed Clinical Director (CD) I, who stated, "we have a computerized program that, as you can see, as you can see, tracks the residents wait by percentage points. When resident's weights are 5 pounds down, we contact the resident's physician." Surveyor requested documentation that Resident 2's physician was notified of weight loss.

On 04/17/2025 at 1:27 p.m., Clinical Director (CD) I confirmed, "There was no call to [Resident 2's] physician regarding his/her weight."

On 04/17/2025 at 1:34 p.m., Surveyor interviewed Clinical Director (CD) I, who stated, "I would hope the weight change was handled diligently prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015615	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENWOOD PARK ASSISTED LIVING	**9535 W LOOMIS RD FRANKLIN, WI 53132**

(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 431	Continued From page 12 us being here. Now, I'm not too sure. The system triggers a pop up for the wellness director to act and call the physician. Obviously, it did not get done."	N 431		