STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014569	A. BUILDING: _____ B. WING _____	C 05/09/2025

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N 000	Initial Comments On 05/08/2025, with information gathered through 05/09/2025, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey and complaint investigation at Brookdale Brookfield Memory Care (0014569), located at 685 Woelfel Road in Brookfield, WI. One citation of noncompliance was issued. The complaint was unsubstantiated. Census: 16	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 1, Resident 2, and Resident 3 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 did not receive polyethylene glycol (prescribed to treat constipation), as prescribed. Resident 2 did not receive Metamucil (prescribed to treat constipation), as prescribed. Resident 3 did not receive eye medications, as prescribed.	N 352		

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

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N 352	Continued From page 1 The findings include: Example 1: Resident 1's polyethylene glycol (powdered bowel medication) On 05/08/2025 at approximately 9:14 A.M., Health and Wellness Coordinator/Licensed Practical Nurse (HWC) C told Surveyor Resident 1 required caregiver administration of all prescribed medications. On 05/08/2025 at approximately 11:03 A.M., Surveyor observed HWC C remove one 30-once daily dose container of polyethylene glycol labeled with Resident 1's name from the facility's medication cart. The container's pharmacy label dated "05/26/24 [2024] 1 of 1" included the practitioner's order including, "Mix 17 grams (fill cap to line) in 4-8 oz of liquid, stir well, and drink once daily." The manufacturer's label included the container originally included "30 once-daily doses [equaling 510 grams]." Surveyor observed HWC C remove the container's lid to reveal one quarter of the powdered medication remained within the container. HWC C told Surveyor this was the only container of polyethylene glycol for Resident 1 at the facility. Photos #1 and #2. On 05/08/2025 at approximately 12:27 P.M., Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy filled and delivered one 30 once-daily dose container for Resident 1, as prescribed, to the facility on 05/26/2024. Pharmacy Staff D told Surveyor this was the only container of polyethylene glycol ever delivered to the facility for Resident 1. On 05/08/2025, Surveyor reviewed Resident 1's record as provided by Assistant Administrator B.	N 352		

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N 352	Continued From page 2 Resident 1 was admitted to the facility on 06/28/2024 with diagnoses including dementia. Resident 1's practitioner's orders included an order dated 06/27/2024 for polyethylene glycol with directions to "Give 1 scoop [17 grams] by mouth one time a day for [to] promote bowel movement." Surveyor reviewed Resident 1's medication administration records (MARs) from 11/01/2024 through 02/16/2025. With in this time frame, Resident 1's MARs included documentation Resident 1 was administered 98 of 108 potential doses, despite the only container delivered to the facility since 05/26/2024 for Resident 1 included one quarter of the original 30 once-daily dose amount of medication. Resident 1's MARs included documentation Resident 1's polyethylene glycol medication was "on hold by physician" for a total of 81 prescribed doses from 02/17/2025 through 05/08/2025. Resident 1's record included an "alert charting note" documented by Health and Wellness Director/Registered Nurse (HWD) E on 02/16/2025 including, "Miralax [polyethylene glycol] on hold until stool is formed." Resident 1's "progress note" on 02/16/2025 included, "Caregivers report [Resident 1] presents today with watery diarrhea...and, Miralax on hold until stool is formed." Resident 1's "progress note" on 02/17/2025 included, "[Resident 1] observed with no diarrhea or emesis [vomiting] today." Resident 1's "progress note" on 02/18/2025 included, "[Resident 1] observed with no s/s [signs/symptoms] of GI [gastrointestinal] at this time." On 05/08/2025 at 11:49 A.M., HWC C told Surveyor Resident 1's polyethylene glycol was put on hold related to a gastrointestinal virus in February 2025 and the hold on the medication was never taken off. HWC C told Surveyor s/he	N 352		

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forgot it had been on hold since February 2025 after Resident 1's gastrointestinal virus resolved, as noted.

Example 2: Resident 2's Metamucil (powdered bowel medication)

On 05/08/2025 at approximately 9:14 A.M., HWC C told Surveyor Resident 2 required caregiver administration of all prescribed medications.

On 05/08/2025 at approximately 11:03 A.M., Surveyor observed HWC C remove one 60-once daily dose, approximately, container of Metamucil labeled with Resident 2's name from the facility's medication cart. The container's pharmacy label dated "07/19/24 [2024] 1 of 1" included the practitioner's order including, "Take 1 tablespoonful [15 grams] by mouth once a day." The manufacturer's label included the container originally included "861 grams" of powdered Metamucil. Surveyor observed HWC C remove the container's lid to reveal the container was almost full. HWC C told Surveyor this was the only container of Metamucil for Resident 2 at the facility. Photos #3, #4, and #5.

On 05/08/2025 at approximately 12:27 P.M., Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy delivered one 861 gram container to the facility, as prescribed, for Resident 2 on 07/19/2024. Pharmacy Staff D told Surveyor this was the most recent container of Metamucil delivered to the facility for Resident 2.

On 05/08/2025, Surveyor reviewed Resident 2's record as provided by Assistant Administrator B. Resident 2 was admitted to the facility on 09/27/2019 with diagnoses including dementia.

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Resident 2's practitioner's orders included an order dated 03/05/2021 for Metamucil with directions to "Give 1 Tbsp [tablespoon] by mouth one time a day for constipation, mix in 4 - 8 oz [ounces] of liquid." Surveyor reviewed Resident 2's MARs from 07/19/2024 through 05/08/2025. Resident 2's MARs within this timeframe included documentation Resident 2 was administered 354 of 358 potential doses, despite the most recent container delivered to the facility since 07/19/2024 for Resident 2 included most of the original 60 once-daily dose amount of medication. Resident 2's MARs within this timeframe included 2 documented refusals, 1 documentation of medication administration opportunity left blank, and 1 dose not administered as documented with code "09." Assistant Administrator B told Surveyor s/he did not know what the code "09" indicated since this code was no longer included within the facility's MARs code key. Assistant Administrator B said s/he would have to figure out what code "09" meant. Surveyor asked Assistant Administrator B to provide Surveyor with this code, if possible, by 05/09/2025 at 4:00 P.M. Surveyor did not receive any feedback from any staff at the facility regarding code "09."

Example 3: Resident 3's eye drop medications

On 05/08/2025 at approximately 9:14 A.M., HWC C told Surveyor Resident 3 required caregiver administration of all prescribed medications.

On 05/08/2025 between approximately 10:59 A.M. through 11:17 A.M., Surveyor observed HWC C remove eye medications labeled with Resident 3's name from the facility's medication cart. Resident 3's Theratears Liquid Gel Night 1 % (carboxmethylcellulose sodium) bag's pharmacy label dated "05/20/24 [2024] 1 of 1"

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included the practitioner's order including, "Instill one drop into left eye three times daily." The bag included 4 unopened packets of 5 single-dose vials, equaling 20 single-dose vials, and 3 loose, single-dose vials not contained within a packet.
Surveyor observed HWC C remove an unpackaged tube of Resident 3's GenTeal Tears lubricant eye gel, approximately half full, including a pharmacy label dated "05/15/24 [2024]" and included the practitioner's order including, "Instill 1 drop in left eye three times daily." The original amount of medication within the container was 10 grams (0.34 fluid ounces).
Surveyor observed HWC C remove one bag containing Resident 3's almost full Artificial Tears (polyvinyl alcohol) 1.4 % 15 milliliter container including a pharmacy label dated "01/03/25 [2025] 1 of 1" and included the practitioner's order including, "Instill 2 drops in both eyes four times daily for dry eyes." Surveyor observed HWC C remove another bag containing Resident 3's almost full Artificial Tears (polyvinyl alcohol) 1.4 % 15 milliliter container including a pharmacy label dated "04/11/25 [2025] 1 of 1" and included the practitioner's order including, "Instill 2 drops in both eyes four times daily for dry eyes."
Surveyor observed HWC C remove a bag containing Resident 3's Systane Nighttime Ointment (white petroleum - mineral oil) tube, almost full, including a pharmacy label dated "09/21/24 [2024]" and included the practitioner's order including, "Apply a small amount to both eyes twice daily for dry eyes." Photos #6 through #12.

On 05/08/2025 at approximately 12:27 P.M., Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy most recently filled and delivered 30 single - dose vials of Theratears Liquid Gel Night 1 % for

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Resident 3 to the facility on 05/20/2024.
Pharmacy Staff D said each single - dose vial would include 3 drops, a daily dose per Resident 3's prescription.
Pharmacy Staff D said the pharmacy filled and delivered 1 container of Artificial Tears (polyvinyl alcohol) to the facility for Resident 3 on 01/03/2025, followed by another container of Artificial Tears (polyvinyl alcohol) for Resident 3 on 04/11/2025. Pharmacy Staff D said this was the last delivery for Resident 3's Artificial Tears prescription. Pharmacy Staff D said each container of Artificial Tears (polyvinyl alcohol) contained approximately 30 days of doses based on Resident 3's prescription. Pharmacy Staff D told Surveyor the order obtained by the pharmacy for this medication was 2 drops in both eyes 4 times per day, as reflected on both containers.
Pharmacy Staff D said the pharmacy most recently filled and delivered a tube of GenTeal Tears lubricant eye gel to the facility for Resident 3 on 05/15/2024. Pharmacy Staff D said the tube would have included approximately 30 days of doses, per Resident 3's prescription.
Pharmacy Staff D said the pharmacy most recently filled and delivered a container of Systane Nighttime Ointment to the facility for Resident 3 on 09/21/2024. Pharmacy Staff D said the container would have included approximately 30 days of doses, per Resident 3's prescription of a small amount to both eyes twice daily.

On 05/08/2025, Surveyor reviewed Resident 3's record as provided by Assistant Administrator B. Resident 3 was admitted to the facility on 11/14/2023 with diagnoses including dementia, macular degeneration (a degenerative eye condition) and glaucoma (an eye condition). Resident 3's practitioner's orders listed on an

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N 352	Continued From page 7 "order summary report" since Resident 3's admission did not include an order for Theratears Liquid Gel Night eye drops. Resident 3's MARs from 05/20/2024 through 05/08/2025 did not include documentation of administration of Theratears Liquid Gel Night eye drops. At 2:50 P.M., HWC C told Surveyor s/he was not sure why Resident 3's order for Theratears Liquid Gel Night eye drops were not reflected on Resident 3's MARs. Resident 3's record included an electronically signed order for GenTeal Tears lubricant eye gel dated 05/15/2024 including, "1 drop in the left eye, three times daily." Surveyor was not provided with documentation of a discontinuation of this order. Resident 3's practitioner's orders included on an "order summary report" including a prescription for GenTeal Tears lubricant eye gel dated 08/08/2024 to be administered as described, "Instill 1 drop in left eye three times a day related to unspecified macular degeneration." Surveyor reviewed Resident 3's MARs from 05/01/2024 through 05/08/2025. Resident 3's May 2024 MAR included documentation GenTeal Tears were administered, as prescribed, from 05/01/2024 through 05/13/2024. Resident 3's May 2024 MAR included Resident 3's GenTeal Tears order was discontinued on 05/13/2024. Resident 3's GenTeal Tears prescription did not appear again within Resident 3's MARs until 08/08/2024. From 08/08/2024 through 05/08/2025, Resident 3's MARs included documentation Resident 3 was administered 798 of 828 potential doses, as prescribed, despite the most recent container delivered to the facility since 05/15/2024 for Resident 3 included approximately half of the original 30 day amount of medication. Resident 3's record included an electronically signed order by Resident 3's practitioner on a	N 352		

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"new prescription summary" dated 01/02/2025 for polyvinyl alcohol ophthalmic solution 1.4 % including, "Instill 2 drops into both eyes 4 times daily for dry eyes." Resident 3's practitioner's orders listed on an "order summary report" included an order for polyvinyl alcohol ophthalmic (relating to the eye) solution 1.4 % dated 01/03/2025 to be administered "Instill 1 drop in both eyes four times a day for dry eyes," instead of 2 drops to both eyes, as prescribed. Resident 3's MARs between 01/03/2025 and 05/08/2025 indicated Resident 3 was to be administered 1 drop, instead of 2 drops, in both eyes four times a day. Therefore, Resident 3's MAR included documentation Resident 3 was administered 988 of 1000 potential doses, despite each container delivered to the facility on 01/03/2025 and 04/11/2025 for Resident 3 included almost all of the of the original 30 day amount of medication remaining in each container.
Resident 3's record included an electronically signed order by Resident 3's practitioner on a "new prescription summary" dated 09/20/2024 for "Systane Nighttime - ointment" including, "Apply a small amount to both eyes 2 times daily for dry eyes." Resident 3's MARs between 09/23/2024 and 01/01/2025 indicated Resident 3 was to be administered Systane Nighttime "1 application in both eyes at bedtime for dry eyes" instead of twice daily, as prescribed. Therefore, Resident 3's MAR from 09/20/2024 through 01/01/2025 included documentation Resident 3 was administered 184 of 204 potential doses.
Resident 3's MARs between 01/02/2025 and 05/08/2025 was changed to indicate Resident 3 was to be administered Systane Nighttime "Instill 1 drop [despite the medication being an ointment] in both eyes two times a day for dry eyes."
Resident 3's MARs between 01/02/2025 and 05/08/2025 included documentation Resident 3

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was administered 498 of 504 potential doses, despite the most recent container delivered to the facility since 09/21/2024 was almost full of the original 30 day amount of medication. At 3:20 P.M., HWC C told Surveyor s/he was confused about Resident 3's eye medication prescription discrepancies and MAR documentation, and s/he would need to do more checking into the situation. HWC C told Surveyor the facility staff, nursing management, transcribed the practitioner's orders for medications from the practitioner's "new prescription summary" orders to the facility's electronic MAR and "order summary report" and errors may have occurred or there was a communication issue with the pharmacy.

On 05/08/2025 at 11:49 A.M., HWC C told Surveyor s/he was not aware the above medications identified for Resident 1, Resident 2, and Resident 3 were not being administered to the residents, as prescribed. HWC C told Surveyor s/he and/or HWD E routinely checked the medication cart for any expired medications on a monthly basis. HWC C said s/he would be adding a review of all resident medications, including medications such as powdered medications, eye drops, topical applications, etc.

On 05/08/2025 at approximately 4:38 P.M., Surveyor conducted an exit interview with Administrator A, Assistant Administrator B, HWC C, and HWD E and discussed the noncompliance regarding Resident 1's, Resident 2's, and Resident 3's medications. HWC C told Surveyor s/he would need to follow-up with the practitioner and/or pharmacy regarding Resident 3's eye medications. Surveyor requested any follow-up to be provided to Surveyor by 05/09/2025 at 4:00 P.M. HWC C and HWD E said they would be

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N 352	Continued From page 10 reviewing all resident medications for any additional noncompliance. On 05/09/2025 at 3:33 P.M., Surveyor received an email from Assistant Administrator B including, "For [Resident 3] - [HWC C] did again reach out to the prescribing eye doctor for clarification of the eye drops, [s/he] left another message - it seems that they are closed on Fridays as their voicemail doesn't [sic] specify Friday operational hours."	N 352		