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	0012537	A. BUILDING: _____ B. WING _____	C 08/25/2025

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BRILLION WEST HAVEN	220 ACHIEVEMENT DR BRILLION, WI 54110

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N 000	Initial Comments On 08/20/2025, with information gathered through 08/25/2025, Surveyor conducted one complaint investigation at Brillion West Haven in Brillion. One of one complaint was substantiated. As a result of the survey, 2 deficiencies were issued. Census: 51	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 record review and interview, the provider did not ensure 1 of 1 (Resident 1) resident reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 had an order for Levofloxacin 750 mg(milligrams) tablet to take one tablet by mouth every day for 7 days, which was delivered to the facility on 03/24/2025 at 8:42PM. Resident 1's MAR (Medication Administration Record) indicated Resident 1 did not receive the 8PM dose on 03/24/2025 due to it not being in the medication cart. Findings Include:	N 352		

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N 352	Continued From page 1 On 07/28/2025, the department received a complaint regarding medication administration. On 08/20/2025, Surveyor conducted an onsite visit to the facility and a sample of residents was selected, including the closed record of Resident 1. Resident 1 was admitted to the facility on 09/03/2024 with diagnoses to include vascular dementia, fracture of shaft of right humerus, and cerebrovascular disease. Resident 1's ISP (Individualized Service Plan) indicated facility staff administer Resident 1's medications. On 03/24/2025, Resident 1 was prescribed Levofloxacin 750 mg(milligrams) tablet to take one tablet by mouth every day for 7 days then stop for pneumonia. Surveyor reviewed Resident 1's March 2025 MAR. The MAR indicated Resident 1 did not receive the medication on 03/24/2025 because it was "not in cart." On 08/20/2025 at 11:35AM, Surveyor interviewed Family Member B. Family Member B verified s/he was the HCPOA (health care power of attorney) for Resident 1. Family Member B stated s/he received a call from facility staff about Resident 1 having a choking incident on 03/23/2025. Family Member B indicated they came to the facility that evening and monitored Resident 1 throughout the night. The next day(03/24/2025), Resident 1's physician came to the facility and ordered a chest x-ray and the x-ray came back positive for aspiration pneumonia. On 03/24/2025, Resident 1's physician ordered the Levofloxacin. Family Member B stated s/he received a call the next	N 352		

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day (03/25/2025) that Resident 1 would not take medications and was sleeping most of the day. Family Member B had asked if Resident 1 had received the first dose of Levofloxacin, to which staff indicated Resident 1 did receive it. Family Member B left work to go to facility to get Resident 1 to take 2nd dose. While driving over to the facility, Family Member B received a call from physician's office informing Family Member B that Resident 1 did not receive the first dose. Upon entering the facility, Family Member B spoke with RN A. RN A informed Family Member B that s/he assumed Resident 1 had taken the Levofloxacin with the other medications last night but reviewed the MAR and saw that s/he did not. RN A indicated to Family Member B that now Resident 1 is not wanting to take any of his/her medications. Family Member B stated that at that point, s/he decided to send Resident 1 to hospital for IV fluids and antibiotics and oxygen. Family Member B indicated s/he called the pharmacy to find out when the medication was delivered to the facility. Family Member B stated the pharmacy had indicated the Levofloxacin was filled and sent to facility on 03/24/2025 and signed in by facility staff at 8:42PM.

On 08/20/2025 at 11:55AM, Surveyor interviewed Pharmacist C. Pharmacist C verified the pharmacy contracts with the facility for medication dispensing. Pharmacist C stated the pharmacy received an order on 03/24/2025 for Resident 1 for Levofloxacin 750 mg(milligrams) tablet to take one tablet by mouth every day for 7 days then stop for pneumonia. Pharmacist C stated the order was filled and sent to the facility on 03/24/2025 at 8:42PM and signed in at the facility by a facility staff member.

On 08/20/2025 at approximately 1:00PM,

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N 352	Continued From page 3 Surveyor interviewed RN A. RN A initially stated the Levofloxacin did not arrive at the facility until the next day (03/25/2025) because it was ordered late in the day and couldn't get it filled. RN A stated now they have a 24/7 number for the pharmacy and can get the medications filled and out to the facility sooner. Surveyor informed RN A that s/he spoke with the pharmacy and pharmacy indicated the medication was delivered on 03/24/2025 at 8:42PM. RN A stated s/he was not aware the medication was delivered to the facility on 03/24/2025. RN A stated the medication was probably not administered that night because it was delivered after the 8PM dose. RN A stated s/he was unaware the medication was delivered on the evening of 03/24/2025. RN A indicated if the medication was delivered on 03/24/2025, the expectation would have been for staff to administer the medication to Resident 1 that evening. In summary, on 03/24/2025 Resident 1 was prescribed Levofloxacin 750 mg(milligrams) tablet to take one tablet by mouth every day for 7 days for aspiration pneumonia. The medication was delivered to the facility on 03/24/2025 at 8:42PM. Resident 1's March 2025 MAR indicated Resident 1 did not receive the medication on 03/24/2025 due to medication "not in cart." On 03/25/2025, Resident 1 was transferred to the emergency room for IV antibiotics, fluids and oxygen. Resident 1 passed away at the hospital on 04/01/2025.	N 352		
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	N 431		

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N 431	Continued From page 4 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 interview, the provider did not monitor the health of the resident and make arrangements for physical health services for 1 of 1 (Resident 1) residents reviewed. Resident 1 had an order to crush medications as needed. Resident 1 was noted to need medications crushed due to swallowing difficulties. Resident 1's record did not contain any communication with Resident 1's physician regarding the need for crushed medications due to swallowing difficulties. On 03/23/2025,	N 431		

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Resident 1 had a choking episode when staff administered medications in pill form. On 03/24/2025, Resident 1 was diagnosed with aspiration pneumonia. On 03/25/2025, Resident 1 was hospitalized for aspiration pneumonia. On 04/01/2025, Resident 1 passed away at the hospital.

Findings Include:

On 07/28/2025, the department received a complaint regarding medication administration.

On 08/20/2025, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the closed record of Resident 1.

Resident 1 was admitted to the facility on 09/03/2024 with diagnoses to include vascular dementia, fracture of shaft of right humerus, and cerebrovascular disease. Resident 1's facesheet indicated Resident 1 had an activated health care power of attorney with an activated date of 08/27/2024. Resident 1's physician admission orders dated 08/27/2025 indicated staff "may crush meds PRN (as needed) if appropriate."

Resident 1's most recent ISP (Individualized Service Plan) dated 01/11/2025 indicated facility staff administer Resident 1's medications. In addition, the ISP indicated staff "May crush medications PRN (If Appropriate) Resident will be able to safely take their scheduled medications; Staff to crush medications; May Crush Medications PRN (If Appropriate) per MD order." Resident 1's ISP also indicated Resident 1 is a "Choking risk; Resident will maintain well-nourished status, maintain weight, and present level of function; Staff to follow diet per

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MD (physician) orders and staff to notify nurse of any coughing/choking episodes while eating and update the MD accordingly. Staff to sit with resident for all meals assisting as required. [Resident 1] is able to feed [him/herself] after set up. [S/he] has a poor appetite and is more of a grazer. Dietary to provide smaller portions and twice daily mighty shakes between meals. Family will have snacks in [his/her] room. Staff to offer throughout the day. 9/07/2024 [Resident 1] had a choking incident at breakfast this morning. When I notified [family member] [s/he] stated that [Resident 1] had an incident at [his/her] previous facility also. Trial of mechanical moist diet initiated, will monitor with meals. 9/09/2024; back to general diet with regular consistency per family request. On 9/10 [s/he] will start eating [his/her] meals in the main dining room for supervision."

Surveyor reviewed Resident 1's facility observation notes. The following was noted:
-10/25/2024 staff noted Resident 1 had "a large emesis after writer gave [his/her] meds this AM[morning]. Writer noticed [his/her] meds were in the emesis."
-10/26/2024 staff noted Resident 1 "...[s/he] had a small amount of vomit on [his/her] shirt. While changing [his/her] shirt, resident pointed out that there was a lot more vomit in [his/her] sheets. It was brown in color, and the consistency of saliva. Resident said [s/he] still felt nauseous..."
-10/27/2024 staff noted Resident 1 stated, "If I eat that, then I will throw up." The note continued to state, "Resident did have an emesis last night. Resident seems to fix on the negative and cannot shake it off and move forward."
-10/27/2024 staff noted "It took caregiver 3 try's to have resident take [his/her] 6a Levothyroxine...Caregiver also could only have

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resident take half [his/her] 8a meds and then had to reapproach to finish [his/her] 8a meds..."
-11/08/2024 Wellness & Director of Resident Services noted, "[Resident 1] does however still have transient episodes of emesis after meals. [Resident 1] is ordered Lactase fast acting to be taken with all meals and is also ordered PRN [as needed]."
-11/10/2024 staff noted, "[Resident's family member] approached writer after dinner and informed me that resident had thrown up randomly at the dinner table. Residents [family member] seemed to be very worried, so writer talked with [him/her] for about 10 minutes and assured [him/her] that I would keep an eye on resident throughout the night..."
-11/19/2024 staff noted, "Resident only took 3 of [his/her] 8a meds. Resident would not swallow [his/her] meds when repeatedly told to. Resident would not hold [his/her] glass with [his/her] mighty shake in it; caregiver helped [him/her]."
-12/12/2024 staff noted, "Resident more confused than usual. When med passer was given [him/her] [his/her] meds and instructing to swallow with water, resident would hold them in [his/her] mouth. When asked if [s/he] had them swallowed, [s/he] would then say "Yes", but still holding them in [his/her] mouth..."
-12/17/2024 staff noted, "Resident did not take [his/her] noon Tylenol and Lactase. Resident sleepy, but mumbles words and moves arms. Resident did not go out for noon meal."
-12/22/2024 staff noted, "when the staff were charting staff noticed the resident spitting the carrots from the lunch on the ground. when the staff asked resident do you not like it. [s/he] looked confused and fell asleep in the chair"
-12/22/2024 staff noted, "Resident stated that [s/he] was very tired and would like to go to bed and skip dinner. [S/he] then woke up around 7:30

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and writer found [him/her] walking down the hall without [his/her] walker. [His/her] shirt and bed sheets were covered in vomit. [S/he] said [s/he] did feel nauseous but didn't anymore...Med passer was notified."
-01/07/2025 staff noted, "Resident very confused. When giving resident [his/her] meds, resident holds pills in [his/her] mouth and needs A LOT of encouragement to swallow them."
-01/09/2025 staff noted, "Med passer having a difficult time getting resident to swallow [his/her] meds. Med passer gives resident 1-2 pills at a time with water and resident will not sallow[sic] [his/her] meds, instead holds them in the mouth. Takes a lot of encouragement for [him/her] to swallow them and at times will spit them out."
-01/10/2025 staff noted, [Resident 1] was in [his/her] wheelchair going to get [his/her] weight. Entered cozy med room on scale and [s/he] started vomiting. Small to medium amount into garbage can...[S/he] is pocketing food when eating and needs help to swallow."
-01/14/2025 staff noted, "..."Needed a lot of encouragement to take [his/her] 8a meds..."
-01/15/2025 staff noted, "[Resident 1] did not eat much at lunch today. While I was at the table with [him/her] [s/he] took a drink of lemonade and water. After [s/he] took a drink of water [s/he] ended up spitting up thick stringy phlegm, there was a ting of color from [his/her] dessert in it, but no solids. POA updated."
-01/17/2025 staff noted, "...Trouble with swallowing [his/her] medication today."
-01/18/2025 staff noted, "Med passer having a difficult time having resident swallow [his/her] 8a meds. Med passer crushed them and put them in [his/her] mighty shake and [s/he] drank that. Resident would not swallow [his/her] probiotic med and spit it out."
-01/19/2025 staff noted, "Med passer had a

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difficult time having resident swallow [his/her] meds. [Family member] present to encourage resident to swallow."
-01/20/2025 RN A noted, "[Resident 1] has been more confused recently and is requiring assist to eat, [s/he] is forgetting how to feed [him/herself]. In the morning, please crush [his/her] meds and give them in [his/her] shake as this is best way at this time to get [him/her] to consistently take [his/her] medication due to difficulty swallowing the pills. [His/her] POA is in agreement with this and we would like to keep this as consistent as possible to reduce the confusion for [Resident 1] on how we are doing things. If you are noticing any shaking or other behaviors please note that so was[sic] can update PCP."
-03/23/2025 at 8:14 PM staff noted, "On call received call from car giver[sic]. Now the emesis is darker in color, almost black. Pulse 156, O2[oxygen] 82%, B/P[Blood Pressure] 100/78. Phone call to [Family Member B]. Notified of [Resident 1's] condition throughout the afternoon. Writer asked [Family Member B] if [s/he] would like [Resident 1] to be seen by a physician. [S/he] asked what the procedure is to have [Resident 1] seen. I explained that if [s/he] wanted [Resident 1] seen, [s/he] could take [him/her] to urgent care in [his/her] private vehicle, or a non emergent rescue squad could be called to take [Resident 1] to urgent care. [Family Member B] has decided to drive to the facility to see [Resident 1] and make decision after [s/he] gets there. I did advise [Family Member B] that I am not in the facility, but am on call. [S/he] has my call back number. I phoned the facility and advised that [Family Member B] is coming in to see [Resident 1], it may take [him/her] 30 minutes to get there. Advised care giver that if anything changes with [Resident 1] to call me. They will call me when [Family Member B] arrives and makes a decision

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regarding possible treatment for [Resident 1].
-03/23/2025 staff noted, "[Family Member B] is at the facility and called me. [S/he] does not want [Resident 1] sent out due to the bad roads. We discussed the possibility of an aspirate pneumonia. [Resident 1] is coughing. [Family Member B] will stay at the facility for a few hours. Advised [Family Member B] staff will check [his/her] temperature throughout the night to make sure [s/he] does not develop an elevated temperature. [Family Member B] and writer agreed if [Resident 1] remains stable we can ask [PCP] to add [him/her] to the visit list tomorrow..."
-03/24/2025 RN A noted, "[Resident 1] is awake, I sat [him/her] up in [his/her] recliner. When asked [s/he] stated that [s/he] felt fine. I took a listen to [his/her] lungs which are very diminished in bases and course rhonchi in right mid lobe. [His/her] heart rate remains elevated. blood pressure normal and oxygen level low at 89%. PCP updated and requested visit today."
-03/24/2025 RN A noted, "PCP in to visit today. STAT chest x-ray ordered..."
-03/24/2025 RN A noted, "X-ray results have come back for [Resident 1] and [s/he] does have pneumonia probable aspiration pneumonia. PCP and family updated. I am expecting antibiotic order to come through yet tonight for her."
-03/24/2025 RN A noted, "Chest x-ray report: Focal left lower lobe (retrocardiac) pneumonic process compatible with pneumonia which may be on the basis of aspiration."
-03/24/2025 RN A noted, "New order: Levofloxacin 750 mg [milligrams] take 1 tablet daily by mouth for 7 days then D/C [discontinue]..."
-03/25/2025 RN A noted, "I talked with [Family Member B] regarding [Resident 1's] condition. [Resident 1] has been very lethargic and did not take any of [his/her] medication today. Staff were

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able to get [him/her] cough medication in but nothing else...When [Family Member B] arrived decision was made with prompting from PCP office to send [Resident 1] to the ER[emergency room].
-04/01/2025 staff noted, "[Staff member] took a call from [hospital]. [Resident 1] passed away at 3:00 pm this afternoon."

Surveyor reviewed Resident 1's March 2025 MAR (Medication Administration Record). Surveyor noted the following:
-03/23/2025, the 4:00PM medication passer stated, "Started choking on them and threw up." This note was written next to the following medications: Acetaminophen 325mg tablet and Lactase Fast Acting 9,000 IU (International Units)
-03/24/2025, MAR updated with "AAA crush meds" instructions to "crush meds and place in mighty shake drink" diagnosis "difficulty swallowing medication"

On 08/20/2025 at 11:35 AM, Surveyor interviewed Family Member B. Family Member B verified s/he was the HCPOA (health care power of attorney) for Resident 1. Family Member B stated the first time s/he was made aware of Resident 1's condition was at 8:15PM, no one had called Family Member B earlier in the day when the choking episode initially happened. Family Member B stated s/he remembers this day because there was a really bad snowstorm outside and it took a long time to get to the facility. Family Member B stated the physician came out to the facility the next day and ordered a chest x-ray and the x-ray showed aspiration pneumonia and an antibiotic was ordered. Family Member B stated the choking incident should have never happened because RN A had wrote a note on 01/20/2025 for all staff to crush

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012537	A. BUILDING: _____ B. WING _____	C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRILLION WEST HAVEN	220 ACHIEVEMENT DR BRILLION, WI 54110

(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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medications due to difficulty swallowing. Family Member B was unaware if there was any follow up with physician after that note to get an order to crush medications going forward.

On 08/20/2025 at approximately 1:00 PM, Surveyor interviewed RN A. RN A indicated Resident 1 had good days and bad days for food and fluid intake as well as for taking medications. RN A stated Resident 1's appetite since admission wasn't great and family had indicated Resident 1 would pick at food. RN A stated this made it difficult to judge if Resident 1 was refusing medications and eating by choice or if Resident 1 was having swallowing difficulties. RN A stated Resident 1 had frequent emesis after eating and therefore was prescribed medication to take prior to eating. RN A indicated Resident 1 did have a choking episode shortly after admission. Speech therapy was ordered and no changes to diet consistency or liquids was made. RN A verified Resident 1 did have an admission order to have medications crushed as needed but no further follow up with the physician was ever made to have medications crushed all the time. RN A stated the facility uses standing physician orders to crush medications and it is left up to each medication passer to know if/when they should crush medications. RN A verified s/he wrote an observation note on 01/20/2025 to crush Resident 1's medications due to swallowing difficulties but did not make note on Resident 1's MAR until 03/24/2025, after the medication choking incident. RN A indicated s/he did not see any communication with physician regarding Resident 1's swallowing difficulties related to food or medications.