STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON 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 02/18/2025 with information gathered through 03/30/2025 Surveyor conducted a standard survey and 2 complaint investigations, and on 03/19/2025, Surveyors conducted 1 complaint investigation at Anita's Garden Brookfield. Six deficiencies were identified. Three complaints were unsubstantiated. Census: 37 on 02/18/2025 37 on 03/19/2025	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation was completed to determine if an incident involving Resident 1 met the definition of abuse or neglect, and if determined to be abuse or neglect report the incident to the Department within 7 calendar days from the date the CBRF knew or should have known about the abuse or neglect. The provider did not investigate possible abuse by a 1:1 outside caregiver when Resident 1 was restrained in his/her wheelchair with a gait belt and sustained injury trying to escape it. By not reporting the incident/investigation to the Department, the provider did not take steps to prevent further incidents of abuse by the caregiver. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to up to 70 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's, physically disabled, traumatic brain injury and terminally ill. DHS 83.02(39) defines physical restraint as "any manual method, article, device, or garment interfering with the free movement of the resident or the normal functioning of a portion of the resident's body or normal access to a portion of the resident's body, and which the resident is unable to remove easily, or confinement of a resident in a locked room." A gait belt is a sturdy belt used to assist with resident transfers.	N 158		

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N 158	Continued From page 2 On 02/18/2025 at approximately 10:45 AM, Surveyor requested Resident 1's record including all incident reports and investigations dated 11/27/2024 - 02/16/2025. On 02/18/2025 with information gathered through 03/26/2025, Surveyor reviewed Resident 1's record and documentation obtained from hospital. S/he was admitted 11/27/2024 with an activated Power of Attorney (POA) for Health Care document with Family Member P serving as agent (legal representative). Diagnoses included: Alzheimer's disease with late onset; dementia in other diseases classified elsewhere, moderate, with agitation; anxiety disorder, unspecified; cognitive communication deficit; unsteadiness on feet; other abnormalities of gait and mobility; and weakness. Incident report dated 02/13/2025 4:30 PM by Executive Director A: " ...Resident was strapped into his/her wheelchair by a 1:1 outside agency caregiver with a gait belt. The resident tried to remove the gait belt and got [his/her] hand caught in the belt tearing [his/her] skin ...Skin tear right hand ...Transported by EMS to ER ..." (Note: hospital documentation identified skin tear was on left hand.) Resident 1's record did not contain an investigation of the 02/13/2025 incident. Emergency Department After Visit Summary dated 02/13/2025: " ...Reason for Visit: Wound Check Diagnosis: Skin tear of left hand without complication ... Instructions: Please keep wound covered and clean. Watch for signs of infection (off white drainage, surrounding redness, warmth), fevers. If these or any new concerns arise please return to the ER ..."	N 158		

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N 158	Continued From page 3 Resident 1's record did not contain a physician order or assessment for a restraint. ISP dated 02/04/2025 did not identify need for physical restraint. On 02/18/2025 at 8:45 AM, Surveyor interviewed Executive Director A who stated Resident 1 required an outside agency 1:1 caregiver due to risk for falls, had a bed alarm and temporary siderails until a concave mattress was obtained to prevent falls out of bed, and had behaviors requiring psychotropic medication adjustments. 02/18/2025 4:09 PM Surveyor interviewed Caregiver I and Caregiver J. Caregiver I stated Resident 1 had a 1:1 caregiver due to behaviors. Caregiver I stated when Resident 1 was belted into wheelchair by the 1:1 caregiver, s/he slid his/her hands under the gait belt fastened around his/her waist and tore his/her skin on gait belt buckle. On 02/18/2025, at 6:20 PM, Surveyor interviewed Executive Director A, Co-Owner L and Assistant Executive Director M. Executive Director A stated they could not find physician orders or an assessment related to Resident 1's hand injury sustained on 02/13/2025 but s/he would ask RN B and provide to Surveyor by noon on 02/19/2025. No physician order or assessment was received. On 02/19/2025 at 1:16 PM, Surveyor interviewed Family Member P who stated Resident 1's cognition had declined significantly during his/her stay at facility and family was there frequently. Family Member P stated due to Resident 1's behaviors the facility required family hire an outside 1:1 24-hour caregiver order to readmit	N 158		

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N 158	Continued From page 4 Resident 1 from hospital on 02/04/2025, which they did. Family Member P stated on 02/13/2025 Resident 1 was seen in ER and received 5-6 loose stitches on hand due to skin tear. On 03/21/2025 at 9:11 AM, Surveyor interviewed Family Member P who stated when Resident 1 was admitted to facility 11/27/2024, s/he was alert and able to converse but due to dementia did not follow directions well. Family Member P stated after a fall on 11/30/2024, Resident 1's lucidity had decreased, and s/he was unable to understand what was happening, and Former LPN C began telling Family Member P Resident 1's behaviors were too much for the staff due to falls and insomnia, however, Executive Director A assured him/her they were able to meet Resident 1's needs. Family Member P stated Resident 1's behaviors worsened including screaming and yelling out, repetitive praying out loud, rocking back and forth, attempting to get out of chair without help, and eventually striking out with attempts to touch him/her. Family Member P stated family received frequent phone calls from staff regarding falls and behaviors and they never had a care conference due to holidays, hospitalizations, and staff turnover. On 02/24/2025 at 11:00 AM, Surveyor discussed a resident's right to be free from physical restraints with Executive Director A, RN B, RN K, Co-Owner N, and RN O. RN B stated Resident 1 experienced increased anxiety due to UTI's and did not return to baseline but continued to be restless and impulsive. Executive Director A stated instead of issuing a 30-day discharge notice they requested family hire the 1:1 caregiver. When Surveyor asked if the 1:1 caregiver had access to Resident 1's ISP, Executive Director A stated, "I don't know that we	N 158		

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N 158	Continued From page 5 would have shared the ISP with the 1:1 caregiver." Executive Director A stated Resident 1 should never have been restrained into the wheelchair. On 04/24/2025 at 10:16 AM, Surveyor received an email regarding the incident with Resident 1 on 02/13/2025 from Executive Director A stating " ...After the incident I told the caregiver the regulations and that they are not to every [sic] retrain [sic] a resident. [S/he] apologized and said [s/he] understood. I did contact [outside caregiving agency Manager S] and left a message but [s/he] never returned my call. I didn't report it to the state because I wanted to speak with [name of outside caregiver agency] first. [Resident 1] didn't return to our community after that incident, and I never followed up with [Manager S] regarding the situation when [s/he] didn't return my call. I do not remember the [1:1 outside agency's] caregiver's name. On 04/24/2025 at 10:35 AM Surveyor responded, "...[Resident 1] returned to facility following the gait belt incident on 02/13/2025. [S/he] did not return to facility following 02/16/2025 ER visit. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 158		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative.	N 310		

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N 310	Continued From page 6 Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all resident's admission agreements were signed by the resident or the resident's legal representative prior to or at the time of admission.	N 310		

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N 310	Continued From page 7 Resident 1's admission agreement was not signed by his/her Power of Attorney for Health Care agent (legal representative) until 20 days after admission. Findings include: On 02/18/2025 with information gathered through 03/26/2025, Surveyor reviewed Resident 1's record. S/he was admitted 11/27/2024 with an activated Power of Attorney for Health Care document (Note: per hospital Social Work note dated 01/20/2025, received 03/10/2025 via fax from hospital, Family Member R rescinded primary POA-HC agent role to Family Member P on 01/20/2025). On 03/26/2025 at 4:04 PM, Surveyor received Resident 1's admission agreement via email from Executive Director A. The admission agreement was signed by Family Member R on 12/17/2024. On 03/30/2025 2:55 PM, Surveyor received an email from Executive Director A stating, " ...What I recall as far as getting the lease signed is [Family Member R] was POA, and [s/he] was also sick and hospitalized around the time [Resident 1] moved in. It was hard to pin down a date and time to have [him/her] come prior to [Resident 1] being released from the hospital to sign the lease ..."	N 310		
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	N 352		

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N 352	Continued From page 8	N 352		

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 the resident right to receive medication as ordered by the physician.

Resident 1 was admitted to provider with a right foot 3rd toe wound and physician orders for scheduled and as needed (PRN) antibiotic ointment and bandage changes. Because the physician order was incorrectly transcribed onto the medication administration record (MAR) the scheduled twice daily orders were not followed and provider produced no documentation the wound was treated twice daily.

Findings include:

On 02/18/2025 with information gathered through 03/26/2025, Surveyor reviewed Resident 1's record. S/he was admitted 11/27/2024 with an activated Power of Attorney (POA) for Health Care document due to inability to make own health care decisions related to dementia. Family Member P served as POA agent (legal representative). Diagnoses included Alzheimer's disease with late onset.

Admission physician orders dated 11/26/2024 included: "Triple antibiotic external ointment-apply [sic] 3rd toe right foot topically as needed (remove bandage, wash with soap and water, dry well, apply TAO to top and side next to second toe, cover with band aid or gauze [sic] 2 times a day and as needed"

Medication Administration Record (MAR) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 352	Continued From page 9 11/27/2024-02/16/2025 (January and February MAR received 02/18/2024, November 2024 and December 2024 MAR received 03/19/2024): The order for triple antibiotic ointment on 11/27/2024-02/04/2025 (stop date) MAR stated, "TRIPLE ANTIBIOTIC 3.5 MG - 400 UNIT- 5,000 UNIT/GRAM (NEOMYCIN/BACITRACIN/POLYMYXINB 3.5 mg-400 unit-5 [sic] Apply Topically to 3rd Right Toe as Directed as Needed up to 3 Times a Day Recommended, Including Scheduled Dose". The order was listed on the MAR only as PRN instead of scheduled twice daily and PRN. There was no order for bandage change on November 2024 MAR. From 12/01/2024-01/31/2025, the MAR included an order for bandage stating "BAND-AID FLEXIBLE FABRIC 1 Apply Topically to Affected Toes as Directed 2 Times a Day and as Needed (wound care)" From 11/27/2024-01/31/2025, the bandage was listed on the MAR only as PRN instead of scheduled twice daily and PRN. From 11/27/2024-01/18/2025 (Resident 1 was hospitalized 01/18/2025-02/04/2025), staff did not document administration of triple antibiotic ointment or bandage changes to 3rd toe right foot. Observation notes dated 11/27/2024-01/18/2025 did not address 3rd toe right foot wound or treatment of it. Temporary ISP (individual service plan) dated 11/27/2024: In the area of Skin/Treatments: Multiple choice	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON 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 352	Continued From page 10	N 352		

list included:
-no concerns,
-non-medicated treatment
-requires medicated treatment, and
-wound treatment.
"No concerns" was checked.

In the area of Medication Management:
"Dependent"

ISP dated 01/16/2025:
In the area of Medication Management: "
...Trained staff will administer all residents [sic] scheduled and as needed medications per MD orders ..."
The ISP did not address right foot 3rd toe wound.

On 03/19/2025 at approximately 9:15 AM, Surveyor interviewed RN K who stated skin assessments and shower skin evaluations were implemented after Surveyor's visit on 02/18/2025. RN K stated they did not document on treatment administration records (TAR), rather, crucial treatments, including skin, were documented on the MAR. At approximately 9:40 AM, RN K stated to Surveyors Resident 1's order for triple antibiotic (ABO) on toe was transcribed incorrectly on the MAR by an outside pharmacy. RN K stated s/he called the pharmacy that transcribed the order for triple ABO had noted in their system. The pharmacist who transcribed the triple ABO order to Resident 1's MAR had called the licensed practical nurse (LPN) on duty at facility and notified him/her the scheduled order for twice daily (BID) application of triple ABO had been written under the 'as needed' (PRN) section of the MAR. The pharmacist notified the facility LPN that the doctor (MD) had written the order for triple ABO in a manner which didn't allow the pharmacist to split the scheduled triple ABO

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N 352	Continued From page 11 treatments from the PRN treatment. The pharmacist instructed the facility LPN to transcribe the scheduled order onto Resident 1's MAR. RN K verified facility nurses had the ability to edit/transcribe resident MARs. The scheduled BID triple ABO treatment (TX) remained under the PRN subsection of the MAR from admission date to stop date. Facility did not administer the scheduled triple ABO TX during that period. RN K stated s/he did not know why the medication passing staff hadn't reported that a scheduled treatment wasn't under the 'scheduled' subsection of Resident 1's MAR, nor the reason the facility LPN hadn't follow the directive from the pharmacist to transcribe the scheduled order for triple ABO TX to the correct subsection of the MAR. On 03/19/2025 at approximately 9:30 AM, Surveyor interviewed Executive Director A regarding Resident 1's toe wound. S/he stated there was a discrepancy between the skilled nursing facility's discharge summary, preadmission assessment and admission physician orders. Executive Director A stated the discrepancy was a problem. Executive Director A stated a referral should have been made to an outside provider for the toe wound treatment. On 03/21/2025 at 9:45 AM, Surveyor interviewed Family Member P who stated Resident 1 had a "bubbly", open, swollen and red wound on his/her toe when admitted to facility. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 352		

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N 381	Continued From page 12	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 interview, the provider did not ensure each resident's needs, abilities, and physical and mental condition were assessed before admitting the person to the CBRF and when there was a change in condition. Resident 1's preadmission assessment identified s/he required encouragement to use call pendant and wait for assistance to transfer due to frequent self-transfers resulting in falls with injuries. The assessment did not address decreased cognition due to Alzheimer's dementia despite admission to the memory care unit. A change of condition assessment was not completed when: s/he developed skin wounds on sacrum; fell multiple times sustaining injuries due poor safety awareness, decreased memory, and dementia related behaviors; had a history of and experienced urinary tract infections (UTI); required a Foley catheter and cognition decreased and behaviors increased.	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON 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 381	Continued From page 13 Example 1- Skin Resident 1 was at risk for skin breakdown (Photos 1, 2, and 3 from hospital record). His/her facility record contained no skin assessments completed to identify risks, existing skin issues and preventative measures. -On 11/27/2024, Resident 1 was admitted to provider with a wound on his/her 3rd toe on right foot and physician order for antibiotic ointment and wound care to treat it. Other than physician order, the provider produced no documentation regarding toe wound. -On 01/18/2024 when Resident 1 was admitted to the hospital, a (4.3 cm length by 5 cm width, and 0.1 cm depth) deep pressure tissue injury on right sacrum (triangular shaped bony structure at base of spine connected to pelvis) was discovered by hospital staff. The provider produced no documentation regarding sacrum wounds. -On 01/27/2025, 8 days prior to Resident 1's discharged from hospital back to provider on 02/04/2025, hospital staff documented reassessment of right sacrum pressure injury and a new stage 3 left sacrum pressure injury. Because the facility did not provide wound care, a referral to home health was required. The referral was not faxed until 02/11/2025, and home health was further delayed because additional physician documentation was required. Other than 02/09/2025 advanced practice nurse prescriber (APNP) note followed by the 02/11/2025 referral to home health, the provider produced no documentation regarding the sacrum wounds. -On 02/13/2024, Resident 1 was seen in ER for a skin tear to dorsum (top) of left hand, requiring 5 stitches. Other than provider's incident report and hospital After Visit Summary both dated 02/13/2025, provider produced no documentation regarding the skin tear.	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 14 Example 2- Falls -From 11/27/2024-02/16/2025, staff documented 11 falls, including 6 with injuries, and 4 of the 6 injuries required emergency room treatment and/or hospitalization. The provider produced no documentation that fall assessments were completed to identify precipitating fall factors or interventions to prevent falls. Example 3- Cognition, Mood and Behaviors On 11/27/2024, Resident 1 was admitted to the memory care unit with services that included staff interventions with behavioral support. -From 11/30/2025-02/13/2025, facility staff documented frequent self-transfers, reminders to use call pendant and wait for staff, anxiety, difficulty sleeping, and use of psychotropic medications. Resident 1 was hospitalized 01/18/2024-02/04/2025. From 02/02/2025-02/04/2025, hospital staff noted: increased confusion; agitation; restlessness; continuous screaming out with no relief after as needed and scheduled psychotropic medication administered; use of hand mitts to prevent pulling Foley catheter out; attempts to climb over siderails; striking at staff; refusing and spitting out medication; and psychotropic medication changes. The provider readmitted Resident 1 back under the condition that s/he have a one-to-one sitter 24 hours per day, 7 days per week by an outside provider paid for by family. -On 02/13/2025, Resident 1 sustained a skin tear requiring 5 stitches while trying to escape a restraint. Other than identifying Resident 1's risk for falls due to frequent self-transfers on the preadmission assessment, the provider produced no assessment(s) identifying cognitive, mood or behavioral issues, nonpharmacological	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 15 interventions to improve mood, sleep and safety, or need for restraint. Findings include: On 02/18/2025 at 10:45 AM, Surveyor requested Resident 1's record from Executive Director A including preadmission, comprehensive, change of condition, skin and fall assessments dated prior to admission to discharge. On 02/18/2025 with information gathered through 04/08/2025, Surveyor reviewed Resident 1's record and documentation obtained from hospitals and home health agency. S/he was admitted 11/27/2024 with an activated Power of Attorney (POA) for Health Care document due to inability to make own health care decisions related to dementia. Family Member P served as POA agent (legal representative). Diagnoses included: Alzheimer's disease with late onset; dementia in other diseases classified elsewhere, moderate, with agitation; anxiety disorder, unspecified; cognitive communication deficit; unsteadiness on feet; other abnormalities of gait and mobility; and weakness. Admission packet received from provider on 02/18/2025 included provider's Preadmission Assessment, physician admission orders, and a skilled nursing facility discharge packet. Admission physician orders dated 11/26/2024 included: Triple antibiotic external ointment to be applied to 3rd toe on right foot as needed and wound care (remove bandage, wash with soap and water, dry well, apply triple antibiotic ointment to top and side next to second toe, cover with band aid or gauze) twice daily and PRN (as needed) (start date: 11/15/2024, discontinued 02/04/2025).	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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N 381	Continued From page 16 Skilled nursing facility discharge plan dated 11/27/2025 stated " ...Nursing managed pain ...skin integrity ..." Provider's Preadmission Assessment (not signed or dated) included (summarized): Diet, weight, dentation, hearing, vision, dressing, toileting, back brace (on in AM and off at bedtime), transfer and mobility status, frequent self-transferring behavior, high fall risk, spiritual involvement, code status, medications, and allergies. Questions regarding nursing procedures, negative behaviors, skin and current treatments were blank. Resident 1's record did not contain any comprehensive, change of condition, skin or fall assessments. Facility incident reports consisted of incident description, resident statement, response to incident (first aid, vitals, pain, request to see physician/transfer to hospital, treatment refusal), MD/family/representative/supervisor notifications, injury description, medications administered within 12 hours prior to incident, and (beginning 12/19/2024) fall risk checks completed prior to incident. They did not include an assessment to identify root cause of fall/injury (physical, cognitive, behavioral, environmental, etc.) and change in needs/interventions to prevent falls. Facility observation notes and incident reports (summarized): 11/30/2024 9:30 AM (incident report by Former LPN C (FLPN-C))- Resident 1 stated s/he fell, complained of right hip pain, sent to ER. 11/30/2024- 9:30 AM (observation note by	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 381	Continued From page 17 FLPN-C)- Complained of left hip pain, educated on importance of utilizing pendant for assistance. 11/30/2024 12:00 PM (observation note by FLPN-C)- Admitted to hospital for closed pelvis ring fracture. 12/12/2024 10:30 AM (observation note by FLPN-C)- Self-transferring, reeducated to use pendant, bed alarm initiated. 12/13/2024 12:30 PM- (observation note by FLPN-C)- UTI symptoms, started antibiotic. 12/17/2024 12:00 PM- (observation note by FLPN-C)- Found on floor, no injuries, educated to use call light. 12/17/2024 4:00 PM (observation note by FLPN-C)- Care staff reported resident not sleeping at night, message left for MD. 12/18/2024 1:15 PM (observation note by FLPN-C)- MD order received for melatonin due to not sleeping at night. 12/19/2024 12:45 PM (observation note by FLPN-C)- unwitnessed fall in bathroom when staff turned around to get gloves, resident attempted to transfer self from wheelchair to toilet. Wheelchair brakes were unlocked at time of fall. Educated resident to wait for staff due to decreased strength. 12/19/2024 12:54 PM (incident report by Staff E)- Witnessed fall. Resident 1 transferred self from wheelchair to toilet as staff turned his/her back to get gloves. No injury. Prior to fall, fall risk checks completed on 12/19/2024 at 2:19 AM, 4:08 AM, and 5:17 AM	N 381		

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N 381	Continued From page 18 12/19/2024 4:20 PM (incident report by FLPN-C)- Staff heard Resident 1 yelling for help, found him/her sitting in recliner holding tissue on right side of head with active bleeding from a small laceration. Resident 1 stated s/he was walking to the door, fell and crawled back to chair. EMS transferred to ER. 12/19/2024 4:45 PM (observation note by FLPN-C)- Unwitnessed fall, active bleeding right side of head. Pressure applied. Neuro checks negative, passive range of motion no signs/symptoms of pain. EMS transported ER. 12/20/2024 2:15 PM (observation note by FLPN-C) Follow-up ER visit post unwitnessed fall, returned to clinic same day with reddened bruising with small hematoma and small laceration on right side forehead, new order for antibiotic (cipro) for 5 days for UTI. Re-educated resident to use call pendant. 12/23/2024 2:00 AM (incident report by Staff F)- Found resident in his/her room lying on floor. Left eyebrow bleeding and swollen, called nurse and reported incident. Prior to fall, fall risk checks completed on 12/22/2024 at 3:40 PM, 7:42 PM, and 10:37 PM, and 11:59 PM. 12/23/2024- 9:00 AM (observation note by FLPN-C)- Unwitnessed fall at 2:00 AM. Left eyebrow swollen. Observed hematoma with small abrasion with small amount of blood on left eyebrow. Band aide applied. Updated MD. New antibiotic (doxycycline) delivered for UTI. 12/27/2024- (observation note by RN B)- " ...Resident observed with purplish reddish	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 19	N 381		

bruising above left eye. Band aid also in place. Also has old hematoma site to left temple region. Both areas for falls earlier this week. Staff also report to writer resident had (2) unwitnessed falls yesterday as a result of resident getting self-up [sic] and ambulating in [his/her] room. Fall pads now in place under resident for safety ...Fax sent to MD to update on residents falls and question prn anti-anxiety medication for resident ..."

12/31/2024 11:10 AM (incident report by Staff G)- Answered call pendant. Found Resident 1 sitting on floor in front of bed, s/he stated s/he walked from recliner to bed without alerting for help. Previously opened skin on forehead reopened and bled. Fall risk checks prior to fall completed at 11:27 PM, 2:41 AM, 4:38 AM, 5:26 AM.

01/02/2025 11:15 AM- (observation note by FLPN-C)- Message left for MD regarding recurrent unwitnessed falls and staff reported resident is very anxious throughout day and at bedtime.

01/08/2025 1:57 AM (incident report by Caregiver D)- Resident 1 observed on floor when staff answered call pendant. Old red marks on face. Fall risk checks completed prior to fall on 01/08/2025 at 12:05 AM, 12:31 AM, 12:38 AM, 12:41 AM, 1:14 AM, and 1:16 AM.

01/08/2025 10:00 AM (observation note by FLPN-C)- unwitnessed fall at 1:57 AM, resident stated pelvis area was sore. Neuro check and active assisted range of motion checked. Called MD and asked if s/he could be sent out for X-ray.

01/09/2024 11:53 PM (observation note by Caregiver D)- observed on bedroom floor. Protocol followed.

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N 381	Continued From page 20 01/10/2025 12:06 AM (incident report by Caregiver D)- Observed on floor near bed. No injuries. Fall risk checks completed prior to fall on 01/09/2025 at 11:45 PM, 11:48 PM, 11:51 PM, and 11:53 PM. 01/10/2025 9:30 AM (observation note by FLPN-C) Received call at 12:50 AM, resident had unwitnessed fall. Assessed, neuro check negative. 01/16/2024 11:14 AM (incident report by Caregiver H)- While doing rounds, heard a commotion and resident yelling for help. Found him/her on floor in front of recliner. Appeared to have hit head on wheelchair near recliner. Bleeding from nose and head, EMS transported to ER. Fall risk checks completed prior to fall on 01/16/2025 at 12:45 AM, 2:38 AM, 2:39 AM, 4:26 AM, and 5:12 AM. 01/16/2025 11:15 AM (observation note by FLPN-C)- fell at 11:07 AM, laying on left side with active bleeding coming from left side of forehead and bridge of nose, alert and oriented to person and place. EMS transported to ER due to head injury. 01/17/2025 8:15 AM (observation note by FLPN-C)- Follow-up unwitnessed fall. Returned to facility 01/16/2025 with diagnoses of hematoma to scalp, forehead/periorbital soft hemorrhage asymmetric to the left and frequent falls. CT scan was negative. Reddened bruises around both eyes and bridge of nose and banged on forehead with a small amount of red blood on gauze. 01/18/2025 10:17 AM (incident report by Staff F)- While doing rounds, staff found resident on floor	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 21	N 381		

in front of recliner. Resident stated s/he slid out of recliner. No injuries noted. RN instructed to call EMS.

02/04/2025 2:00 PM (observation note by RN B)- "Resident returned back to facility today via ambulance service from [name of hospital]. Resident accompanied by [family]. Resident alert per baseline- [oriented] to self, however, recognizes family. Resident in good spirits. Denies pain. [Vital signs] 97.6, HR 80 RR 20, SPO2 96% BP 129/79. Lungs Clear [sic]. [Abdomen] soft. B.S. + x's 4 [sic]. Per resident's [family] appetite and intake today 'good' for lunch. Had [moderate] soft BM afterward. Foley catheter patent with approx. 100 ml amber urine in leg bag. Faded purple colored bruising remains to skin under bilateral eyes/upper cheeks. 1:1 caregiver also present in resident's room for safety monitoring. [New orders noted per [hospital] DC summary ([multi vitamin], Vit B12, VIT C, Melatonin [sic] and Seroquel [sic]) [sic] DC summary faxed to [name of pharmacy]. Copy of discharge summary also faxed to [name of nurse practitioner] for review."

02/10/2025 8:15 AM (observation note by RN B)- Call received by writer on early morning hours of 02/08/2025 from night shift caregiver, sent to ER early morning on 02/08/2025 due to complaints of pain all over and spitting out pain medication. Returned 02/08/2025 with new orders for antibiotic for UTI.

02/11/2025 3:00 PM (observation note by RN B)- Referral for home health for physical and occupational therapy and skilled nursing for wound care.

02/13/2025 11:30 AM (observation note by RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 22 B)- updated nurse practitioner that resident is frequently awake at night, per private duty caregivers, is only sleeping 5-10 minutes then wakes up. 02/13/2025 4:30 PM (incident report by Executive Director A) " ...Resident was strapped into his/her wheelchair by a 1:1 outside agency caregiver with a gait belt [sturdy belt used to assist with transfers]. The resident tried to remove the gait belt and got [his/her] hand caught in the belt tearing [his/her] skin ...Skin tear right hand ...Transported by EMS to ER ..." (Note: hospital documentation identified skin tear was on left hand.) 02/18/2025 10:30 AM (observation note) "[New order received] noted for Zyprexa [olanzapine] 2.5mg [twice daily]. Order faxed to [name of pharmacy]. Resident remains out of facility at this time." (Note: Per hospital documentation s/he was hospitalized 02/16/2025 due to sepsis and self-inflicted skin tear on top of left hand.) Medication Administration Record (MAR) dated 11/27/2025-02/16/2025 identified the following psychotropic medications (Note: Per DHS 83.02(41), a psychotropic medication is a prescription drug used to treat or manage a psychiatric symptom or challenging behavior.): -Olanzapine (Zyprexa) 2.5 MG 1 tablet at bedtime started 12/16/2024, stopped 01/10/2025, -Rivastigmine [Exelon] 4.6 MG/24 hour apply 1 patch topically in AM (and remove old patch before applying new one) start 01/09/2025, stopped 02/11/2025. -Seroquel 25 MG1 tablet in evening and 4 tablets (100MG) at bedtime, started 02/04/2025, and Seroquel 25 MG 1 tablet every 4 hours as needed (PRN) for agitation, started 02/04/2025. Staff	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 23	N 381		

documented administering PRN Seroquel 25 MG once daily on 02/05/2025, 02/08/2025, 02/09/2025, 02/10/2025, 02/12/2025 and 02/13/2025.

Temporary ISP (individual service plan) dated 11/27/2024:
-In the area of Skin/Treatments: Multiple choice list included no concerns, non-medicated treatment, requires medicated treatment, and wound treatment. "No concerns" was checked. Temporary ISP did not address right foot 3rd toe wound.

ISP dated 01/16/2025 (Note: Page 2 of ISP missing. First section, I. Activities of Daily Living begins on page 4, and last section, IV. Physical Health ends on page 8. Compared to ISP dated 02/04/2025, diagnoses, general questions, and list of medications was missing from ISP dated 01/16/2025. On 02/25/2025 at 10:43 AM, Surveyor received an email from Administrator A stating they were unable to find the ISP's missing pages.)

ISP dated 01/16/2025 did not address right foot 3rd toe wound.

ISP dated 02/04/2025:
-In the area of General Questions: Nursing Procedures was blank.

-In the area of Chronic Illnesses:
"RESIDENT'S NEEDS/PREFERENCES DX: Dementia, depression, hypertension, hyperlipidemia, Cognitive [sic] chronic kidney disease. Allergies ...Code Status...POA ...
FREQUENCY OF SERVICE AND SERVICE PERFORMED Chronic Illness
RESIDENT'S DESIRED GOALS AND

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 24 OUTCOMES [blank] SERVICE PROVIDER RESPONSIBILITIES Resident will be monitored daily for changes in condition. MD will be updated with changes & concerns. All residents' [sic] medications will be administered by trained staff per MD orders. MD appointments as scheduled. Labs as scheduled MEASURABLE GOALS, OUTCOMES AND REVIEW Residents' [sic] health will remain stable with no hospitalizations x's 6 months [sic]" -In the area of Nursing Procedures: "Resident needs/preferences listed as "Not Applicable" Frequency of service and services performed, desired goals and outcomes, provider responsibilities and measurable goals/outcomes/review were blank. -In the area of Short-Term Illness: "RESIDENT'S NEEDS/PREFERENCES Needs wound care an [sic] PT and OT. Referral made." Frequency of service and services performed, desired goals and outcomes, provider responsibilities and measurable goals/outcomes/review were blank. Admission Agreement dated 12/17/2024 (received from Executive Director A via fax 03/26/2025 at 4:04 PM) identified Resident 1 required Advanced Care (Level 3) in memory care. Five choices were listed under Level 3 care with need for moderate staff assistance with dressing and grooming, incontinence care, and consistent staff intervention with behavioral support checked. On 03/19/2025, Surveyor reviewed the facility Program Statement dated 08/02/2024 on file with the Department stating " ... Anita's Gardens is licensed to accept individuals who need care due to advanced age, Alzheimer's disease or other	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 25 type of dementia, physical disabilities... Dementia specific programming and a higher resident to caregiver ratio will be part of the services offered in our memory care program. We will work closely with dementia specialists and behavioral health to minimize behavior issues... A registered nurse will provide admission assessments, health monitoring, ongoing education and preparation of individual service plans (ISP) ...The RN is responsible for the health assessment and monitoring of residents' [sic] health... The RN will work with the administrator, resident, caregivers, case managers and family to develop, review and revise individual's service plan....a dementia care specialist will assist the RN and activity specialist in training staff and developing a behavioral support plan as needed..." Emergency Room and Hospital Documentation 11/30/2024-12/10/2024 Hospital documentation dated received 03/10/2025 via fax from hospital: -11/30/2024 Emergency Department Note: " ...The patient reports unwitnessed fall at approximately 9 AM. Reports [s/he] is supposed to walk with a walker but [s/he] did not use it lost [his/her] balance and tripped and fell ...[Family] at bedside reports that [s/he] has a history of dementia and frequently forgets to use [his/her] walker ..." -Hospital Discharge Summary dated 12/10/2025: " ...Reason for hospitalization: Mechanical fall, R obturator [pelvis] ring fracture ... Discharge diagnoses: Displaced right obturator ring fractures with small amount of hemorrhage ... Fractures of the right sacral ala [bone at base of spine] and right transverse process of L5 [fracture of bony prominence of lower back vertebrate] ... Major medication changes and reasons ...Added Zyprexa 2.5 mg nightly for delirium/agitated ... S/he] is discharged to Anita Gardens ALF with	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 26 Therapies ...Patient needs frequent changes in body position. Patient ultimately needing hospital bed for safe discharge ...Condition at discharge: Patient was discharged to Anita Garden ALF with PT/OT in stable condition ...Physical Exam ...Abrasions noted to the right lateral mid back. Bruising on hips bilaterally ..." 12/19/2024 Emergency Department record (received 03/07/2025 at 10:10 AM via fax from hospital): "...[Family Member] ...reports that the patient actually fell at [his/her] memory care center. [S/he] has a history of dementia and is never supposed to walk on [his/her] own without assistance from staff. [S/he] has a history of frequent falls the past year due to trying to walk on [his/her] own ... patient does have a history of recurrent UTI's ...according to [family] the patient seems a bit more confused than usual the past week ...Patient has a small hematoma on [his/her] right forehead with a tiny skin tear ...daughter/POA was agreeable with skin glue ..." 01/16/2025 Emergency Department record (received 03/10/2025 via fax from hospital): " ...Patient arrives via [EMS] from facility ...[Chief complaint] of unwitnessed ground level fall ...on the ground about 10-15 minutes. Did hit head (hematoma to head noted by EMS with minor-moderate bleeding) ...Unknown if [s/he] had [loss of consciousness]. [History] of dementia. Reporting head pain and mouth pain ... Impression: Forehead/periorbital soft tissue hemorrhage asymmetric to the left ..." 01/18/2025-02/04/2025 hospital documentation (received 03/10/2025 via fax from hospital): -Internal Medicine History and Physical dated 01/18/2025: " ...Pt arriving from ...assisted living ...pt had a	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 27 sitter and [s/he] left the room and when [s/he] came back pt was on the floor laying on [his/her] side. Pt was seen here for a fall two days ago as well. No [loss of consciousness], bruising on pt it [sic] from previous fall per staff. Baseline pt is AOx2 [alert and oriented to person and place], [history] of dementia ..." -01/21/2025 Flowsheet (summarized): Right: deep pressure tissue injury [DTI] (evolving), sacrum Date first assessed: 01/18/25 (Photo 2) Length 4.3 cm, Width 5 cm, Wound Depth, 0.1 cm Blanchable erythema; Fragile Scant amount of drainage -01/27/2025 Wound/Skin Nurse Specialist Follow Up (summarized) (Photos 1 and 2): Left: stage 3 left sacrum pressure injury (Photo 3) Length 1.2 cm, Width 1.4 cm, Depth 0.1 cm Moderate amount of drainage Right: deep pressure tissue injury [DTI] (evolving), sacrum Date first assessed: 01/18/25 Length 4.3 cm, Width 5 cm, Wound Depth, 0.1 cm Blanchable erythema [redness of skin]; Fragile Scant amount of drainage " ...Assessment ... - Present on Admission: Pressure Injury: DTI to the Right Sacral Region - Present on Admission: Pressure Injury: Stage 3 to the Left Sacral Region Recommendations/Plan of Care: Wound Care Treatment to Sacrum: 1. Cleanse wound with Puracyn Plus, saturate gauze and soak x5 minutes. 2. Pat dry with gauze. 3. Apply 3M Cavilon barrier to intact DTI to right	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 381	Continued From page 28 sacrum and peri-wound skin. 4. Cover open wound to left sacral region with Hydrofera Blue Transfer. 5. Secure with Sacral Mepilex. RN to assess wound and change dressing 3x/week and as needed with saturation. Mark dressings with date applied. Current Inpatient Supplies: 4x4 Gauze (for cleansing), Hydrofera Blue Transfer Mepilex Border (size: Sacral), and Puracyn Plus Spray Cleanser Discharge Supplies: Same as Above ...Preventative Measures: ... Turn patient every 2 hours, utilizing Right, Left, and Back turning surfaces. Pad bony prominences ...Float heels off of bed with pillows ...Keep head of bed < [less than] 30 degrees whenever possible, unless contraindicated ...INCONTINENCE CARE - Utilize incontinence management PRN: Cleanse with Barrier Cream Wipes [sic] ...Apply Z-Guard as needed with incontinence. When soiled, gently wipe away any soiled cream (do not scrub away entire layer). Reapply as needed ....NO BRIEFS - Do not use incontinence briefs in bed ...Single layer moisture wicking underpad [sic] to be used for incontinence management in bed ...SEAT CUSHION - Utilize Static Air [sic] cushion when in chair. Teach patient to adjust self Q [every] 15 minutes and stand Q hour for pressure relief, if possible ...Use Patran Sheet with bed transfers/repositioning to avoid shearing and skin dragging ...Moisturize skin with: Skin Repair Cream [sic] ...Discharge Planning: Utilize above wound care instructions in discharge environment ..." -02/04/2025 3:44 AM Flow Sheet - " ...Pt AOX 0-1 ...Scheduled and PRNs given for agitation, restless, impulsiveness w/no effect. Pt	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 29	N 381		

continuously screaming out, pulling at foley [sic], trying to climb over side rails, removing mitts. Tele obs [remote camera and audio observation] and bed alarm on activated. Safety maintained ..."

-02/03/2025 11:09 PM Hospitalist Note " ...Called by bedside RN ...Patient with extreme agitation [sic] Striking at staff [sic] Yelling out [sic] Unable to be redirected Plan: Zyprexa ..."

-02/03/2025 3:00 AM Flow Sheet- " ...Pt A&Ox0-1. Scheduled nightly seroquel [sic] dose given, pt continuing to call out and remove stat-lock [device to minimize movement of foley [sic] catheter] from leg, mitts applied for safety. PRN seroquil [sic] attempted x1, pt refused and spit medication out while attempting to bite staff. PRN seroquil [sic] attempted x1 again, pt complied, medication and pt not attempting to bite/call out temporarily. Bed alarm on and teleobs in place."

-02/02/2025 2:47 AM Flow Sheet- " ...Pt A&O to self. Scheduled nightly seroquel [sic] dose administered, pt continuing to call out with no relief. PRN seroquil [sic] given x2 in addition to scheduled dosage with no relief ...Bed alarm on and teleobs in place ..."

-Psychiatry Follow-Up note dated 02/02/2025 at 6:13 PM " ...Assessment ... admitted to [name of hospital] on 1/18/2025 with late onset Alzheimer's dementia, multiple recent falls and memory care. Rivastigmine patch had recently been started ...causing worsened symptoms, patch discontinued delirium factor appears resolved at this point. Patient with obvious facial bruising and likely degree concussion as a result of [his/her] fall, this was likely a contributor or even the full cause of the delirium. Patient tends to get

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	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 30	N 381		

restless and agitated with evening hours more likely sundowning. Would continue quetiapine [Seroquel] 25mg at [4:00 PM] and quetiapine 100 mg at [8:00 PM] to hopefully give better overnight coverage of agitation and better sleep ..."

-Discharge Note dated 02/03/2025:
"Reason for hospitalization: Recurrent falls ...
Discharge diagnoses:
Recurrent falls with overall weakness and now left pelvic fractures
Dementia with behavioral disturbance
Urinary retention ...
Anemia
Rib fracture ...6 [6th] rib right ...
Major medication changes and reasons:
...Seroquel at 4 pm and 8 pm 25 at 4 pm and 100 nightly ...Prn Seroquel ...
urinary retention ...requiring straight [catheter] ...will discharge with Foley catheter ...Rib fracture, 6 rib fracture right Pain control Incentive spirometry ..."

-Social Work Discharge Coordination/Progress notes
-01/27/2025: " ...Clinicals sent ..."
-01/30/2025: " ...Writer received a call from [RN B] ...indicating they can manage prn's at their facility. Update provided to [RN B] ...Unclear when private hire care can start, likely pending outcome of assessment tomorrow ..."

-02/04/2025: " ...Also advised that SNF [skilled nursing facility] is not an option when requiring mitts, prns, etc [sic] ...[FLPN-C] contacted writer [on] 1/23 ...a condition to return would be for family to hire additional 1:1 care because of the number of falls and injuries patient has sustained ...Patient is to be discharged today, 2/4/2025 ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 31	N 381		

-02/04/2025 at 12:14 PM: " ... Writer attempted to call report to facility with no answer. DC Packet completed, script included. HHC [home health care] order included. Faxed signed DC summary with med list and [pharmacy] DC summary to Anita's Gardens ...No further needs ..."

02/13/2025 Emergency Department After Visit Summary (received from provider 02/18/2025): " ...Reason for Visit: Wound Check Diagnosis: Skin tear of left hand without complication ... Instructions: Please keep wound covered and clean. Watch for signs of infection (off white drainage, surrounding redness, warmth), fevers. If these or any new concerns arise please return to the ER ..."

02/13/2025 Emergency Department note (received 04/08/2025 at 9:07 AM from hospital): " ...Bruising to right hand and patient reporting tenderness to proximal digits 2 through 4. Left hand with dorsal skin tear, patient with exposed ligaments however bleeding controlled ...Length (cm) 2.5 ...Repair type: Complex ...Number of sutures: 5 ...Dressing: Bulky dressing ...discussed wound care with family who will let facility know recommendations of keeping wound covered, washing at least 1-2 times per day with regular soap and water and watching for signs of infection. Sutures are absorbable therefore do not need to be removed ..."

02/16/2025 Emergency Department note (received via fax 03/07/2025 at 10:11 AM from hospital): " ...Patient present in critical condition at imminent risk of disability of death. Interventions included: ED sepsis protocol, broad spectrum antibiotic fluid History: " ...was seen here 3 days ago with skin tear to the dorsum of [his/her] left hand, apparently this morning [s/he] was more

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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 32 agitated and removed skin from the dorsum of both hands ...Physical Exam ...Dorsum of left hand demonstrates a Steri-Stripped [sic] skin tear there is some surrounding erythema [redness], it is warm, there is no purulence [pus]. On the right hand demonstrates a reported self-inflicted skin tear 7 cm in length ...Sepsis with encephalopathy [change in brain function] without septic shock, due to unspecified organism ...Acute UTI ..." Discharge Summary dated 02/19/2025 "End stage dementia with terminal delirium. Likely precipitated by UTI. Comfort care initiated ...passed away on 02/19/2025 ..." 02/09/2025 Physician Progress Note (received from home health 03/14/2025): " ...Recommendations/Orders: Discontinue Exelon Patch, SN/PT/OT [skilled nursing/physical therapy/occupational therapy] to eval and treat: Generalized weakness, falls, pressure ulcer to right buttock, foley [sic] management ...[S/he] recently had an extended hospitalization form 1/18-2/4/25. Hospitalization was the result of a fall with left pelvic fracture, rib fracture and several compression fractures. The hospital kept [him/her] longer as they were attempting to adjust [his/her] psych medications ...Since [his/her] return from the hospital [s/he] has a 1:1 caregiver for safety ...S/he also has a small stage 2 pressure ulcer and needs home care ...S/he has a foley [sic] in place due to urinary retention. Foley not draining correctly and was replaced after visit ...PSYCH: Alert, Restless, Mood-Euthymic...Falls frequently: Multifactorial related to impulsiveness, poor safety awareness, unsteady gait ...Severe late onset Alzheimer's dementia with other behavioral disturbance: Appropriate [memory care] resident. Behaviors: Agitation, Restlessness ...Cognitive function, a SLUMS was completed with a score of 0/30 ..."	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 33	N 381		

(Note: According the S. Louis University Mental Status Exam (SLUMS) form, scoring 27-30 indicates normal cognitive functioning (Source: https://health.mo.gov/seniors/hcbs/hcbsmanual/pdf/4.00appendix8slumsform.pdf (retrieval date 03/27/2025.))

02/11/2025 fax from RN B to home health (received 03/13/2025 at 2:14 PM via fax from home health): The fax contained: referral for PT, OT and skilled nursing; physician order dated 02/10/2025 for PT, OT and skilled nursing; hospital discharge summary dated 02/04/2025; physician progress note dated 02/09/2025; and home health agency Client Coordination Notes Report.

Home health Client Coordination Note dated 02/12/2025 stated " ...SPOKE WITH [RN B] AT [assisted living facility], [S/HE] WANTED UPDATED [SIC] ON REFERRAL. LET [HIM/HER] KNOW REFERRAL INCOMPLETE AT THIS TIME AWAITING [PHYSICIAN FACE TO FACE VISIT NOTE] AND CONFIRMATION OF FOLLOWING PCP [PRIMARY CARE PHYSICIAN]. MESSAGE LEFT FOR PCP OFFICE AND STAT MEDICAL RECORDS REQUEST SENT."

On 02/18/2025 at 8:45 AM, Surveyor interviewed Executive Director A who stated Resident 1 required a 1:1 caregiver due to risk for falls, had a bed alarm and temporary siderails until a concave mattress was obtained to prevent falls out of bed, and had behaviors requiring psychotropic medication adjustments. Executive Director A stated Resident 1 was not on hospice service and was currently hospitalized since 02/16/2025.

On 02/18/2025 at 4:44 PM, Surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 34 RN K who stated if a resident returns from the emergency room with stitches a baseline assessment should be completed to include description of wound, temperature, pain, etc. Any new physician orders and instructions should be documented, for example if it can get wet, how and what to bandage it with, follow up appointment, wound care referral, and stitches removal. On 02/18/2025, at 6:20 PM, Surveyor interviewed Executive Director A, Co-Owner L and Assistant Executive Director M. Executive Director A stated they could not find physician orders or an assessment related to Resident 1's hand injury sustained on 02/13/2025 but s/he would ask RN B and provide to Surveyor by noon on 02/19/2025. Executive Director A stated s/he was not aware how long outside agency 1:1 caregivers restrained Resident 1 into his/her wheelchair prior to it reported to him/her on 02/13/2025. On 02/19/2025 at 12:26 PM, Surveyor received an email from Executive Director A stating, " ...I spoke to [RN B] regarding [Resident 1's] return on 2/13 with stitches. [RN B] said the incident happened at 4:30 pm when [s/he] had already left the building for the day. [RN B] did not return to work until Monday 2/17 and [Resident 1] was sent out again on Sunday the 16th. So, there was no nurse present and no nurse to do the stitches assessment when [s/he] returned ..." On 02/20/2025 at 1:07 PM, Surveyor received an email from Executive Director A stating, " ...Regarding [Resident 1] I could not find any MD orders regarding [his/her] stitches. Just a 2-page discharge with little information. The discharge paperwork does not say how many stitches [s/he]	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 35	N 381		

received. Our protocol when someone returns from the hospital is to get the discharge paperwork from the resident and if there are any changes to notify the nurse on call if they are not present at the community. In [Resident 1's] case [s/he] returned to the community [RN B] was gone already and didn't return until Monday 2/17 when [Resident 1] was already sent back out. [RN B] never got a chance to see [him/her]. I personally visited [Resident 1] on Saturday 2/15 and saw that [his/her] hand was bandaged and wrapped ..."

On 02/19/2025 at 1:16 PM, Surveyor interviewed Family Member P who stated Resident 1's cognition declined significantly during his/her stay at facility. Family Member P stated due to Resident 1's behaviors the facility required family hire an outside 1:1 24-hour caregiver order to readmit Resident 1 from hospital on 02/04/2025, which they did and paid $989.00 per day for.
On 03/21/2025 at 9:45 AM, Surveyor interviewed Family Member P who stated Resident 1 had a "bubbly", open, swollen and red wound on his/her toe when admitted to facility 11/27/2024. Family Member P stated the sacrum wound was ongoing and exacerbated when readmitted back to facility on 02/04/2025 and s/he discussed it with RN B because the bandage needed changing every 3 days.
Family Member P stated when Resident 1 was admitted to facility 11/27/2024, s/he was alert and able to converse but due to dementia did not follow directions well. Family Member P stated after the fall on 11/30/2024, Resident 1's lucidity had decreased, s/he could not understand what was happening, and FLPN-C began telling Family Member P Resident 1's behaviors were too much for the staff due to falls and insomnia, however, Executive Director A assured him/her they were

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	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 36	N 381		

able to meet Resident 1's needs.
Family Member P stated Resident 1's behaviors worsened to screaming/yelling out, repetitive praying out loud, rocking back and forth, attempting to get out of chair without help, and eventually striking out with attempts to touch him/her. Family Member P stated Resident 1 did not pick at his/her skin often but frequently tried to pull the Foley catheter out. Family Member P stated family received frequent phone calls from staff regarding falls and behaviors and they never had a care conference due to holidays, hospitalizations, and staff turnover.

On 02/21/2025 at 3:36 PM, Surveyor received an email from Executive Director A stating, " ...I have attached the fax to [home health agency name] that our RN sent over on 2/11. I do not see any incident report or observation note that there was a fall or an incident. I would have to confirm with [RN B], but I believe the order was for something else ..."

On 02/24/2025 at 9:08 AM, Surveyor emailed Executive Director A asking, "Do you have any MD/psychiatry/other outside provider progress notes you can send (other than hospital notes) for [Resident 1] ...?" On 02/24/2025 at 9:08 AM Executive Director A emailed response stating, " ...I do not see any in [his/her] chart ..."

On 02/24/2025 at 11:00 AM, Surveyor discussed concern regarding lack of assessments with Executive Director A, RN B, RN K, Co-Owner N, and RN O. RN B stated Resident 1 experienced increased anxiety due to UTI's and did not return to baseline but continued to be restless and impulsive. RN B stated Resident 1's difficulty sleeping and standing was brought to his/her attention by the 1:1 caregiver on 02/13/2025 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 381	Continued From page 37	N 381		

may have been caused by dementia but s/he was not sure. RN B stated assessments were not completed for falls and falls may have contributed to his/her dementia. Executive Director A stated Resident 1's ability to remember to use call light was slim to none, at times s/he would just press it because it was there. Executive Director A stated they initiated safety checks approximately 12/23/2024, and the 30-minute night checks on 01/17/2025. RN B stated on 02/10/2025 Resident 1 was agitated, calling out and staff could not console him/her with regular interventions. RN B stated the referral on 02/11/2025 to home health for skilled nursing was due to a pressure sore that s/he returned from hospital with on 02/04/2025. RN B stated s/he was not aware of the wound and s/he did not assess or update Resident 1's ISP regarding the wound due to perhaps being distracted. RN B stated when s/he left work early on 02/13/2025 for the weekend, the 02/13/2025 After Visit Summary was left in a file the caregivers had access to and the on call nurse may not have been notified. RN B stated there was no documentation on 02/16/2025 why Resident 1 was sent to ER. RN O stated s/he was the nurse on call 02/16/2025 and had received a call that Resident 1's hand needed to be evaluated, and no incident report was completed. RN B stated they were going to issue a 30-day discharge notice and Co-Owner N stated the discharge notice would have been due to falls and restlessness. Executive Director A stated instead of issuing a 30-day discharge notice they requested the 1:1 caregiver. When Surveyor asked if the 1:1 caregiver had access to Resident 1's ISP, Executive Director A stated, "I don't know that we would have shared the ISP with the 1:1 caregiver."

On 03/11/2025 at 12:21 PM, Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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N 381	Continued From page 38 emailed Surveyor stating, "The pre assessment [sic] was completed face to face on 11/7/2024." On 03/13/2025 at 1:36 PM, Surveyor interviewed Home Health Q who stated home health for therapy and wound care did not start with the 02/11/2025 referral because a face-to-face physician visit and confirmation was required and then Resident 1 was hospitalized on 02/16/2025. On 03/19/2025 at approximately 9:15 AM, Surveyor interviewed RN K who stated skin assessments and shower skin evaluations were implemented after Surveyor's visit on 02/18/2025. RN K stated they did not document on treatment administration records (TAR), and crucial treatments, including skin, were documented on the MAR. RN B stated s/he did not know if skin treatments were provided to Resident 1 because s/he was hired afterwards. At approximately 9:40 AM, RN K stated to Surveyors Resident 1's order for triple antibiotic on toe was transcribed incorrectly on the MAR because the scheduled and PRN orders were combined and listed as only PRN on the MAR. On 03/19/2025 at approximately 9:30 AM, Surveyor interviewed Executive Director A who stated RN B created the preadmission form and FLPN-C conducted Resident 1's Preadmission Assessment. Executive Director A stated Resident 1's preadmission assessment did not include behaviors or mental health and there was a discrepancy between the skilled nursing facility's discharge summary, the preadmission assessment and admission physician orders. Executive Director A stated the discrepancy was a problem. Executive Director A stated there should have been a referral made to an outside provider for the toe wound.	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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N 381	Continued From page 39 Cross Reference: N0352 DHS 83.32(3)(g) Rights of Residents: Physical Restraints N0352 DHS 83.32(3)(h) Rights of Residents Receive Medication N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 381		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan was revised when there was a change in resident's needs or the resident's legal representative signed the individual service plan acknowledging their involvement in, understanding of, and agreement with the individual service plan. Resident 1's individual service plan (ISP) did not identify need or interventions for back brace and	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 389	Continued From page 40	N 389		

was not updated with all interventions utilized to prevent falls, monitoring for urinary tract infection or management of Foley catheter.
Findings include:
On 02/18/2025 with information gathered through 03/31/2025, Surveyor reviewed Resident 1's record.
S/he was admitted 11/27/2024 with an activated Power of Attorney (POA) for Health Care document due to inability to make own health care decisions related to dementia. Family Member P served as POA agent (legal representative). Diagnoses included: Alzheimer's disease with late onset.

Preadmission Assessment (not signed or dated) identified need for back brace (on in AM and off at bedtime), frequent self-transferring behavior, and high risk for falls.

Observation notes and incident reports included (summarized):
11/30/2024 9:30 AM (Incident report)- Resident 1 stated s/he fell, complained of right hip pain, sent to ER.
11/30/2024- 9:30 AM (observation note)- Complained of left hip pain, educated on importance of utilizing pendant for assistance.
11/30/2024 12:00 PM (observation note)- Admitted to hospital for closed pelvis ring fracture.
12/12/2024 10:30 AM (observation note)- Self-transferring, reeducated to use pendant, bed alarm initiated.
12/17/2024 12:00 PM- (observation note)- Found on floor, no injuries, educated to use call light.
12/19/2024 12:45 PM (observation note)- unwitnessed fall in bathroom when staff turned around to get gloves, resident attempted to transfer self from wheelchair to toilet. Wheelchair

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N 389	Continued From page 41	N 389		

brakes were unlocked at time of fall. Educated resident to wait for staff due to decreased strength.
12/19/2024 12:54 PM (incident report)- Witnessed fall. Resident 1 transferred self from wheelchair to toilet as staff turned his/her back to Resident 1 to get gloves. No injury. Prior to fall, fall risk checks completed on 12/19/2024 at 2:19 AM, 4:08 AM, and 5:17 AM
12/19/2024 4:20 PM (incident report)- Staff heard Resident 1 yelling for help, found him/her sitting in recliner holding tissue on right side of head with active bleeding from a small laceration. Resident 1 stated s/he was walking to the door, fell and crawled back to chair. Ems transferred to ER.
12/19/2024 4:45 PM (observation note)- Unwitnessed fall, active bleeding right side of head. Pressure applied. Neuro checks negative, PROM no s/s of pain. EMS transported ER.
12/20/2024 2:15 PM (observation note) Follow-up ER visit post unwitnessed fall, returned to clinic same day with reddened bruising with small hematoma and small laceration on right side forehead, new order for antibiotic (cipro) for 5 days for UTI. Re-educated resident to use call pendant.
12/23/2024 2:00 AM (incident report)- Found resident in his/her room lying on floor. Left eyebrow bleeding and swollen, called nurse and reported incident. Prior to fall, fall risk checks completed on 12/22/2024 at 3:40 PM, 7:42 PM, and 10:37 PM, and 11:59 PM.
12/23/2024- 9:00 AM (observation note)- Unwitnessed fall at 2:00 AM. Left eyebrow swollen. Observed hematoma with small abrasion with small amount of blood on left eyebrow. Band aide applied. Updated MD. New antibiotic (doxycycline) delivered for UTI.
12/27/2024- (obs. note by RN B)- " ...Resident observed with purplish reddish bruising above left

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N 389	Continued From page 42	N 389		

eye. Band aid also in place. Also has old hematoma site to left temple region. Both areas for falls earlier this week. Staff also report to writer resident had (2) unwitnessed falls yesterday as a result of resident getting self-up [sic] and ambulating in [his/her] room. Fall pads now in place under resident for safety ...Fax sent to MD to update on residents falls and question prn anti-anxiety medication for resident ..."
12/31/2024 11:10 AM (incident report)- Answered call pendant. Found Resident 1 sitting on floor in front of bed, s/he stated s/he walked from recliner to bed without alerting for help. Previously opened skin on forehead reopened and bled. Fall risk checks prior to fall completed at 11:27 PM, 2:41 AM, 4:38 AM, 5:26 AM.
01/08/2025 1:57 AM (incident report)- Resident 1 observed on floor when staff answered call pendant. Old red marks on face. Fall risk checks completed prior to fall on 01/08/2025 at 12:05 AM, 12:31 AM, 12:38 AM, 12:41 AM, 1:14 AM, and 1:16 AM.
01/08/2025 10:00 AM (observation note)- Unwitnessed fall at 1:57 AM, resident stated pelvis area was sore. Neuro check and active assisted range of motion checked. Called MD and asked if she could be sent out for X-ray.
01/09/2025 (observation note) observed on bedroom floor. Protocol followed.
01/10/2025 12:06 AM (incident report)- Observed on floor near bed. No injuries. Fall risk checks completed prior to fall on 01/09/2025 at 11:45 PM, 11:48 PM, 11:51 PM, and 11:53 PM.
01/10/2025 9:30 AM (observation note) Received call at 12:50 AM, resident had unwitnessed fall. Writer assessed, neuro check negative.
01/16/2025 11:14 AM (incident report)- While doing rounds, heard a commotion and resident yelling for help. Found him/her on floor in front of recliner. Appeared to have hit head on wheelchair

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N 389	Continued From page 43 near recliner. Bleeding from nose and head, EMS transported to ER. Fall risk checks completed prior to fall on 01/16/2025 at 12:45 AM, 2:38 AM, 2:39 AM, 4:26 AM, and 5:12 AM. 01/16/2025 11:15 AM (observation note)- Fell at 11:07 am, laying on left side with active bleeding coming from left side of forehead and bridge of nose, alert and oriented to person and place. EMS transported to ER due to head injury. 01/17/2025 8:15 AM (observation note)- Follow-up unwitnessed fall. Returned to facility 01/16/2025 with diagnoses of hematoma to scalp, forehead/periorbital soft hemorrhage asymmetric to the left and frequent falls. CT scan was negative. Sitting up in wheelchair at dining room tablet alert with usual mentation. Reddened bruises around both eyes and bridge of nose and banged on forehead with a small amount of red blood on gauze. Denies pain at this time. 01/18/2025 10:17 AM (incident report)- While doing rounds, staff found resident on floor in front of recliner. Resident stated s/he slid out of recliner. No injuries noted. RN instructed to call EMS. 02/04/2025 2:00 PM- Returned from hospital. Foley catheter patent, faded purple colored bruising remains to skin under bilateral eyes and upper cheeks, 1:1 caregiver present in resident's room for safety monitoring. 02/10/2025 8:15 AM (observation note)- Sent to ER early morning on 02/08/2025 due to complaints of pain all over and spitting out pain medication. Returned 02/08/202525 with new orders for antibiotic for UTI. 02/13/2025 4:30 PM (incident report by Administrator A) " ...Resident was strapped into his/her wheelchair by a 1:1 outside agency caregiver with a gait belt. The resident tried to remove the gait belt and got [his/her] hand caught in the belt tearing [his/her] skin ..." Skin tear right	N 389		

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N 389	Continued From page 44	N 389		

hand. Transported by EMS to ER.
Hospital Discharge Note dated 02/03/2025 received 03/10/2025 via fax from hospital: "Reason for hospitalization: Recurrent falls ...Major medication changes and reasons: ...Prn Seroquel ...urinary retention ...will discharge with Foley catheter ..."

02/13/2025 Emergency Department note (received 04/08/2025 at 9:07 AM from hospital): " ...Bruising to right hand and patient reporting tenderness to proximal digits 2 through 4. Left hand with dorsal skin tear, patient with exposed ligaments however bleeding controlled ...Length (cm) 2.5 ...Repair type: Complex ...Number of sutures: 5 ...Dressing: Bulky dressing ...discussed wound care with family who will let facility know recommendations of keeping wound covered, washing at least 1-2 times per day with regular soap and water and watching for signs of infection. Sutures are absorbable therefore do not need to be removed ..."

Hospital Discharge Planner notes received 03/10/2025 via fax from hospital:
-01/30/2025: " ...Writer received a call from [RN B] at Anita's Gardens indicating they can manage prn's at their facility. Update provided to [RN B] ...Unclear when private hire care can start, likely pending outcome of assessment tomorrow ..."

-02/04/2025: " ...[Former LPB C] contacted writer [on]1/23 and updated that a condition to return would be for family to hire additional 1:1 care because of the number of falls and injuries patient has sustained ...Patient is to be discharged today, 2/4/2025 ..."

Physician progress note dated 02/09/2025 (received 03/13/2025 at 2:14 PM via fax from

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N 389	Continued From page 45	N 389		

home health): " ...Visit Findings: ...- foley [sic] management ... Falls frequently. Patient now with 1:1 caregiver for safety. Maintain fall prevention interventions."

02/09/2025 Emergency Department Record received 03/10/2025 via fax from hospital:
" ...Narrative of Situation (Chief Complaint): Poss. UTI.
[Assisted living facility nurse] states [Resident 1] has been trying to take [his/her] catheter out the last few days. Not sleepy and a little aggressive ..."

ISP
Temporary ISP (individual service plan) dated 11/27/2024:
In the area of Transfer Abilities/Evacuation: Encourage to use pendant and wait for staff, will frequently self-transfer.
In the area of Mobility/Transportation: Wheelchair for distance, 2 wheeled walker with assist of 1
In the area of Adaptive equipment/Appliance: Dependent
In the area of Dressing: Set up for dressing, 12/10/2024- requires assist of 1 with dressing.
ISP dated 11/27/2024 did not identify need and/or instructions for back brace.

ISP dated 01/16/2025 (not signed):
(Note: Page 2 of ISP missing. First section, I. Activities of Daily Living begins on page 4, and last section, IV. Physical Health ends on page 8. Compared to ISP dated 02/04/2025, diagnoses, general questions, and list of medications was missing from ISP dated 01/16/2025. On 02/25/2025 at 10:43 AM, Surveyor received an email from Administrator A stating they were unable to find the ISP's missing pages.)

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	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 389	Continued From page 46 In the area of Mobility and Transferring: -Needs/preferences: "Resident requires staff monitoring and/or reminders and cues when ambulating ... requires stand assist with all transfers ... ambulates with 2 wheeled walker ... unwitnessed fall sent to ER for evaluation of [left lower extremity] 11/30/24 requires bed alarm d/t high fall risk 12/12/24 Unwitnessed fall 12/17/2024 [sic] Utilize pendant Unwitnessed fall 12/19/24 intervention educated resident to wait for assistance with transfers and toileting. Unwitnessed fall on 12/23/24 keep resident in common areas when awake ... Unwitnessed fall on 12/31/24 Educated resident on the importance of utilizing [his/her] pendant for all transfer assists. unwitnessed [sic] 01/08/25 Pain management notified [primary care physician] Unwitnessed fall 01/10/25 Reeducated resident on [sic] to utilize the pendant for assist with transfers. unwitnessed [sic] fall Fell 01/16/2025 sent to ER for evaluation and treatment of head injury." -Frequency of service and services performed: "Ambulation-Monitor and Cue ..." -Desired goals and outcomes: "To safely move from place to place as desired." -Service Provider responsibilities: " ...frequently remind resident to use the call pendant to call and wait for assistance with all transfers ... encourage resident to be in common areas of facility when not in bed for extra safety monitoring. ensure resident is wearing pendant at all times ...	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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ANITAS GARDENS OF BROOKFIELD	15735 W LISBON RD BROOKFIELD, WI 53005

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N 389	Continued From page 47	N 389		

encourage resident to utilize pendant for assistance ...
ensure bed alarm is on while resident is in bed ...
remind resident to use pendant for assistance."

-Measurable goals, outcomes and review:
"Resident will have no falls with injury x's 6 months."

ISP dated 02/04/2025 (not signed):
In the area of Mobility and Transferring: same as 01/16/2025 ISP except:
Needs/preferences: added 2-person transfer, hands on assist with all positioning needs, and scheduled pain medication.

Frequency of service and services performed: added full assistance with ambulation.

Desired goals and outcomes- no change.

Service provider responsibilities: added keep in common area when not in bed when awake.

In the area of Toileting:
Needs/preferences included " ...requires full assistance from staff to complete toileting tasks. Required with foley [sic] catheter."

Frequency of services and service preformed " ...Toileting-Full Assistance As Needed Every Day"

Desired goals and outcomes " ...To remain clean and dry."
Service provider responsibilities - Blank

02/04/2025 ISP did not include instructions regarding back brace, 30-minute safety checks (initiated 01/17/2025), 1:1 caregiver (initiated 02/04/2025), fall mat, or interventions to monitor

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N 389	Continued From page 48 and manage foley catheter. On 02/18/2025 at 8:45 AM, Surveyor interviewed Executive Director A who stated Resident 1 required a 1:1 caregiver due to risk for falls, had a bed alarm and temporary siderails until a concave mattress was obtained to prevent falls out of bed. Executive Director A stated Resident 1 was not on hospice service and was currently hospitalized since 02/16/2025. On 02/19/2025 at 1:16 PM, Surveyor interviewed Family Member P who stated the facility required family hire an outside 1:1 24-hour caregiver for readmission back to facility from hospital on 02/04/2025, which they did and paid $989 per day for. On 03/21/2025 at 9:45 AM, Surveyor interviewed Family Member P who stated Resident 1's back brace was initiated in July 2024 after a fall with compression fractures and it was with Resident 1 when s/he was admitted to facility. Family Member P stated there was no care conference during Resident 1's stay due to staff turnover and holidays. On 02/24/2025 at 11:00 AM, Surveyor discussed concern regarding ISP not updated with Executive Director A, RN B, RN K, Co-Owner N, and RN O. Executive Director A stated they initiated Resident 1's safety checks on approximately 12/23/2024, and the 30-minute night checks on 01/17/2025. RN B stated they planned to issue a 30-day discharge notice and Co-Owner N stated the discharge notice would have been due to falls and restlessness. Executive Director A stated instead of issuing a 30-day discharge notice they requested the 1:1 caregiver. When Surveyor asked if the 1:1 caregiver had access to Resident 1's ISP, Executive Director A stated, "I don't know that we	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 389	Continued From page 49 would have shared the ISP with the 1:1 caregiver." RN B stated s/he did not update the ISP perhaps due to distractions. On 03/30/2025 at 2:55 PM, Surveyor received an email from Executive Director A stating, " ...I'm not sure why the ISP wasn't signed by the POA. I would have to do some investigating since the nurse is no longer employed with us ..." Cross Reference: N0352 DHS 83.32(3)(g) Rights of Residents: Physical Restraints N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0408 DHS 83.37(1)(i) PRN Psychotropic Medication	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020307	A. BUILDING: _____ B. WING _____	C 04/24/2025

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N 408	Continued From page 50 monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when a psychotropic medication was prescribed on an as needed (PRN) basis, the resident's individual service plan (ISP) included the rationale for use and a detailed description of the behaviors indicating the need for PRN medication administration. Resident 1's ISP did not include the rationale for use and detailed description of the behaviors indicating the need for administration of PRN quetiapine (Seroquel). Findings include: Per 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". On 02/18/2025 with information gathered through 03/26/2025, Surveyor reviewed Resident 1's record. S/he was admitted 11/27/2024. Diagnoses included dementia in other diseases classified elsewhere, moderate, with agitation. 02/04/2025 12:15 PM (observation note by RN B)- Signed hospital discharge summary received from [name of hospital]. [New orders] noted for ...Seroquel ..." MD order dated 02/03/2025- quetiapine 25 MG 1 tablet every evening and 4 tablets (=100 MG) nightly at 8:00 PM; and quetiapine 25 MG 1 tablet every 4 hours as needed.	N 408		

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N 408	Continued From page 51 February 2025 medication administration record (MAR): Staff documented administration of PRN quetiapine 02/05/2025, 02/08/2025, 02/09/2025, 02/10/2025, 02/12/2025 and 02/13/2025. ISP dated 02/04/2025: In the area of anti-psychotic medication information: " ...Quetiapine Fumarate 25 Mg (Seroquel 25 Mg) [name of physician] Side Effects: Immediately Report to Md [sic] Any Thoughts of Suicide, may Cause Drowsiness/dizZiness [sic], drive With Caution avoid Alcohol/other Drugs That Make You Sleepy [sic] drink Fluids and Try to Avoid Getting Too Hot [sic] Route: Oral (by mouth) ..." In the area or Medication Management: " ...RESIDENTS NEEDS/[REFERENCES [List PRN psychotropic medications, rationale for use, and a detailed description of the behaviors which indicate the need for administration] FREQUENCY OF SERVICE AND SERVICE PERFORMED Medication Management-Staff Administer PRN Psychotropic Medication RESIDENT'S DESIRED GOALS AND OUTCOMES SERVICE PROVDER RESPONSIBILITIES Resident will be safe and comfortable within [his/her] environment x's 6 months MEASURABLE GOALS, OUTCOMES AND REVIEW ... Trained staff will administer all residents [sic] scheduled and as needed medications per MD orders. All residents' [sic] medications will be administered by trained staff per Md [sic] orders. Prior to staff administering a PRN antipsychotic medication, staff will: Ask resident if they have	N 408		

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N 408	Continued From page 52 any pain or discomfort and offer a PRN pain medication if needed, [sic] Ask resident if they need to use the bathroom or assist resident with toileting if it has been over two hours, [sic] Ask resident if they are hungry or thirsty and offer them a snack, [sic] If above interventions are ineffective, staff will then administer the medication as ordered and monitor its effectiveness." The ISP did not include rationale for use and a detailed description of behaviors indicating the need for administration of PRN medication. On 02/24/2025 at 11:00 AM, Surveyor discussed concern regarding PRN psychotropic not adequately addressed on ISP with Executive Director A, RN B, RN K, Co-Owner N, and RN O. RN B stated s/he did not update the ISP perhaps due to distractions. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 408		