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 _____	R-C 06/25/2025

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 06/25/2025, Surveyors conducted 1 verification visit and 1 complaint investigation at Anita's Gardens of Brookfield. Three deficiencies were identifed. One of 3 deficiencies was a repeat violations. See Statement of Deficiency (SOD) OS1E11, dated 04/24/2025. Five of 6 deficiencies from SOD OS1E11, dated 04/24/2025 were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 47	{N 000}		
{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.	{N 389}		

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

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{N 389}	Continued From page 1	{N 389}		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure individual service plans (ISP) were updated when there was a change in a resident's needs, abilities or physical condition for 2 of 3 residents reviewed.

Resident 3's ISP did not identify nonpharmacological interventions for pain or address cognition or mood when s/he had a diagnoses of early onset Alzheimer's disease, resided on the memory care unit, was no longer able to make own health care decisions, verbalized pain and displayed nonverbal indicators of pain, and was prescribed pain and mood-altering medications.

Resident 4's ISP did not identify his/her diagnoses of dementia and depression, or the interventions related to suicidal ideation.

This is a repeat deficiency. See Statement Of Deficiency (SOD) OS1E11 dated 04/25/2025.

Findings include:

On 06/25/2025 at 11:38 AM, Surveyors interviewed Caregiver U who stated Resident 3 was limping, crying and complaining of back pain until his/her spouse brought in a heating pad. Caregiver U stated from approximately 06/12/2025-06/19/2025 Resident 3 repeatedly said s/he was not feeling well, held his/her head in his/her hand, stayed in his/her room and frequently requested Tylenol.

On 06/25/2025 at 12:54 PM, Surveyor interviewed Lead Caregiver V who stated s/he observed Resident 3 sitting on the edges of chairs due to pain. Lead Caregiver V stated staff

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{N 389}	Continued From page 2 called Resident 3's spouse who brought in a heating pad. On 06/25/2025, Surveyors interviewed RN K who stated Resident 3's back pain was the result of an old injury. RN K stated sometimes Resident 3 did not want any pain medication and other times requested Extra Strength Tylenol. RN K stated Resident 3 leaned to the left when standing due to back pain, was able to verbalize needs accurately and verbalized pain. RN K stated Resident 4 had been to hospital approximately 5 times, had MRI's due to headaches. RN K stated Resident 4 was started on Tramadol due to pain. RN K stated Resident 4 intermittently believed s/he heard something living in the wall. On 06/25/2025, Surveyors reviewed Resident 3's and Resident 4's records. Example 1- Resident 3 Resident 3 was admitted 09/04/21024. His/her Power of Attorney for Health Care was activated as s/he was no longer able to make own health care decisions. Resident 3 resided on the memory care unit. Diagnoses included Alzheimer's disease with early onset; unspecified mood disorder; migraine without aura; chronic pain, other; rectal prolapse; pain in right and left shoulders; and spinal stenosis. Physician orders included: fluoxetine HCL 40 MG 1 capsule in AM; cyclobenzaprine HCl 5 MG 1 tablet at bedtime; gabapentin 300 MG 1 tablet 3 times per day; acetaminophen 325 MG1 tablet in AM and 2 tablets every 4 hours as needed.	{N 389}		

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{N 389}	Continued From page 3 Comprehensive Assessment dated 04/28/2025 by RN K (summarized): Prior to admission, Resident 3's memory issues had increased. Since admission, s/he was independent with pain management except staff to monitor. No mental illness and no behaviors. Resident 3 was independent with mobility, toileting, grooming and oral cares, and required cues and assistance to wash lower body, assistance with housekeeping and laundry, and reminders for activities. A goal identified on the assessment was to be free from anxiety. Pain Assessment dated 03/17/2025 by RN K- " ...Is the individual currently in pain? Yes ...lower back stiffness noted, uncomfortable at times ... [Resident 3] reports intermittent pain/discomfort and limited range of motion to [his/her] bilateral shoulders ...Is the individual able to verbalize pain? Yes ...Has the care plan been updated to reflect current pain evaluation? Yes ..." ISP dated 04/28/2025 In the area of Pain History and Management- "Resident's Needs/Preferences: shoulder and lower pain [sic] pain Resident's Desired Goals & Outcomes: To be free of pain ...Service Provider Responsibilities: monitor. The ISP did not address cognition or mood, and did not identify specific pain management interventions. Example 2- Resident 4 On 06/25/2025, Surveyor reviewed Resident 4's facility record. Resident 4 was admitted to the facility on 02/18/2025. Resident 4 had an activated power of attorney. Resident 4 was diagnosed with but not limited to: dementia, depression and anxiety disorder.	{N 389}		

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{N 389}	Continued From page 4 On 06/25/2025, Surveyor reviewed Resident 4's observation notes. On 05/05/2025 at 6:30 PM, Nurse Z documented the following, "Staff reported that the resident stated [s/he] no longer wants to live..." On 06/25/2025, Surveyor reviewed Resident 4's clinical after visit summary dated 06/05/2025. The section , "Today's Visit," documented Resident 4 was seen about his/her chronic pain, depression, and moderate dementia symptoms. On 06/25/2025, Surveyor reviewed Resident 4's ISP. Resident 4's ISP was signed on 04/02/2025. Under the subsection titled, "CHRONIC ILLNESS." there were zero diagnoses listed. Surveyor did not find interventions related to Resident 4's suicidal ideation, dementia, depression or anxiety documented in the ISP. On 06/25/2025, Surveyor reviewed documentation of 15-minute safety checks completed on Resident 4 from 05/05/2025 to 05/06/2025. On 06/25/2025 at 3:30 PM, Surveyors discussed Resident 4's record and ISP with RN K, Executive Director A, and Regional Director T. RN K stated Resident 4 did suffer from short term memory loss related to his/her dementia diagnosis. RN K stated Resident 4's 15-minute safety checks were performed in response to his/her suicidal statement on 05/05/2025. RN K reported Resident 4 was not observed harming himself/herself during that time. RN K and Executive Director A acknowledged Resident 4's diagnosis of depression, suicidal ideation, nor intervention of 15-minute safety checks had been documented in the ISP. RN K and Executive Director A acknowledged Resident 4's diagnosis	{N 389}		

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{N 389}	Continued From page 5 of dementia and related interventions/goals were not documented in the ISP.	{N 389}		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin's uniform controlled substances act, ch 961, Stats, that contained the date and time administered or the administrator designee audited, signed and dated the proof-of-use record on a daily basis. FINDINGS INCLUDE: On 06/20/2025, the Department received a complaint concerning medication management at the facility. On 06/25/2025, Surveyors arrived at facility for a complaint investigation. On 06/25/2025 at 9:00 AM, Surveyor initiated a medication cart audit with RN K. RN K escorted	N 409		

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N 409	Continued From page 6 Surveyor to the medication room on the memory care side of the facility. RN K introduced Surveyor to Caregiver W. Caregiver W stated s/he had completed a narcotic count with Caregiver X at the beginning of his/her shift. Surveyor and Nurse K initiated a narcotic count. Surveyor and RN K counted 15 syringes of Resident 5's liquid morphine 100 MG/5 ML, then reviewed the number recorded on the proof-of-use record to be 16. Nurse K asked Caregiver W if s/he had administered a vial of liquid morphine to Resident 5 that morning. Caregiver W denied administering liquid morphine to Resident 5 that morning. RN K searched the entire medication cart and could not find the 16th vial of Resident 5's oral morphine. Surveyor reviewed the pharmacy label on Resident 5's oral morphine, the pharmacy documented 20 vials of liquid morphine were dispensed to the facility on 05/08/2025. RN K reviewed Resident 5's medication administration record (MAR) in the electronic health record (EHR) from 05/08/2025 to 06/25/2025. RN K and Surveyor counted 4 doses of liquid morphine had been documented as administered. Surveyor reviewed the narcotic count and did not see where an administrator or designee had signed/dated their daily audit of the proof-of-use record. RN K stated 2 caregivers from each shift signed the narcotic count. RN K acknowledged the proof-of-use record had not been signed daily by an administrator or designee. Surveyor and RN K counted 56 tablets of Resident 6's hydrocodone-acetaminophen (APAP) 5-325 MG as needed (PRN) dose, then reviewed the number recorded on the proof-of-use record was 57. Surveyor reviewed the pharmacy label on Resident 6's PRN hydrocodone-APAP 5-325 MG, the pharmacy documented 60 tablets had been dispensed to the facility on 06/09/2025. RN K reviewed Resident 6's MAR from 06/09/2025 to	N 409		

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N 409	Continued From page 7	N 409		

06/25/2025. RN K and Surveyor counted 3 tablets of hydrocodone-APAP 5-325 MG had been documented as administered.

EXAMPLE 1: Resident 5

On 06/24/2025, Surveyor reviewed Resident 5's "CONTROLLED DRUG USE RECORD," for his/her morphine sulfate 100 MG/5 ML vials. There were 20 vials documented as dispensed on 05/08/2025. From 05/10/2025 to 05/16/2025, there were 4 doses of morphine sulfate were documented as administered, leaving a final count of 16. Surveyor did not see an administrator or administrator's designee's signature on the document.

On 06/24/2025, Surveyor reviewed a "medication replacement request" completed by Executive Director A. On 06/05/2025, Executive Director A documented that Resident 5's morphine sulfate needed to be replaced because it fell to the ground.

EXAMPLE 2: Resident 6

On 06/24/2025, Surveyor reviewed Resident 6's "CONTROLLED DRUG USE RECORD," for his/her hydrocodone-APAP 5-325 mg tablets. There were 60 tablets documented as dispensed on 06/09/2025. From 06/09/2025 to 06/14/2025, there were 3 doses of hydrocodone-APAP were documented as administered, leaving a final count of 57.

EXIT INTERVIEW:

On 06/27/2025 at 3:30 PM, Surveyor discussed the above concerns with Executive Director A, RN K and Regional Director T. RN K explained

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N 409	Continued From page 8 Caregiver W had recalled forgetting to document that s/he had administered Resident 6's hydrocodone-APAP 5-325 MG on 06/22/2025. RN K provided Surveyor with the corrected proof-of-use record for Resident 6. RN K acknowledged facility staff had not accurately completed a count of the hydrocodone-APAP from 06/22/2025 to 06/25/2025. RN K explained on 06/05/2025 a staff dropped a vial of Resident 5's morphine and forgot to document it on the proof-of-use record. RN K acknowledged that facility staff had not accurately completed a count of morphine sulfate vials from 06/05/2025 to 06/25/2025. Executive Director A and RN K acknowledged the administrator nor designated administrator hadn't audited/signed the proof-of-use record daily.	N 409		
N 480	83.42(3) Access to resident records. The employee in charge on each work shift shall have a means to access resident records. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure employees in charge on each work shift had a means to access Resident 2's records. On 06/19/2025, Resident 2 went into cardiac arrest in the resident dining room. RN K instructed Caregiver U to look up Resident 2's code status in the electronic health record (EHR). Caregiver U told RN K of Resident 2's full code status. RN K then initiated cardiopulmonary resuscitation (CPR) on Resident 2. The local fire department arrived on scene and took over CPR from RN K. Executive Director A then produced	N 480		

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N 480	Continued From page 9	N 480		

Resident 2's advanced directive with "do not resuscitate" (DNR) order. The local fire department stopped CPR/life saving measures on Resident 2

FINDINGS INCLUDE:

On 06/20/2025, the Department received a complaint regarding code status.

On 06/25/2025, Surveyors arrived at the facility for a complaint investigation.

RECORD REVIEW:

On 06/25/2025, Surveyor reviewed Resident 2's face sheet. Resident 2 was admitted to the memory care unit on 09/30/2024. Resident 2 was code status was documented as "DNR".

On 06/25/2025, Surveyor reviewed Resident 2's individualized service plan (ISP). The ISP was signed on 03/25/2025.

On 06/25/2025, Surveyor reviewed Resident 2's observation notes. On 06/19/2025 at 9:30 AM, RN K documented the following, "Resident was observed slummed [sic] over the breakfast table[sic] moved to room. 911 call [sic] compressions started DNR validated compression started by RN thern [sic] police then firedepartment [sic]. Stop by fire department. [Primary Care Physician] call [sic] at 840am [sic] and [family] notified on [his/her] was in to the facility 30 mins out. Spoke with [medical examiner] cardiac arrest cause of death ..."

INTERVIEWS:

On 06/25/2025 at 11:38 AM, Surveyor discussed

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the above incident with Caregiver U. Caregiver U stated Resident 2 became slumped over their wheelchair while in the dining room. Caregiver U immediately summoned RN K to assess Resident 2. RN K instructed a different caregiver to call 911. RN K then instructed Caregiver U to help Resident 2 from the dining room to their room. Caregiver U described Resident 2 having a decreased level of consciousness with twitching movements. RN K asked Caregiver U to look up Resident 2's code status; and the computer said s/he was a full code. Caregiver U reported after RN K was told Resident 2 was a full code, RN K initiated CPR. Caregiver U stated the local fire department/EMTs (emergency medical technicians) arrived and behind them was Executive Director A. Executive Director A had the official DNR paperwork and showed it to the fire department. Once the fire department saw the DNR order they stopped CPR/life saving measures on Resident 2. Caregiver U reported most residents who had a DNR order wear a DNR bracelet. Caregiver U reported s/he had never seen Resident 2 wearing a DNR bracelet.

On 06/25/2025 at 12:30 PM, Surveyor discussed the above incident with RN K. RN K reported staff immediately found him/her to help Resident 2. RN K reported Resident 2 had a decreased level of consciousness and was not able to stabilize his/her own weight. RN K stated s/he had staff call 911. RN K stated before the EMTs arrived s/he asked Caregiver U to look up Resident 2's code status in the EHR. RN K stated s/he initiated CPR after being notified of the full code status. RN K reported after EMTs took over the scene. Executive Director A entered the room with Resident 2's advanced directive and DNR order. RN K reported EMTs then stopped CPR/life saving measure on Resident 2. RN K stated

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N 480	Continued From page 11 Resident 2's EHR record had inaccurately documented Resident 2 as a full code. RN K stated since the incident s/he had updated Resident 2's code status in the EHR. RN K stated s/he had s/he been given access to the DNR order at the appropriate time, s/he would not have initiated CPR. On 06/25/2025 at 3:30 PM, Surveyor discussed the above incident with Executive Director A, RN K and Regional Director T. Executive Director A, RN K and Regional Director T acknowledged had Resident 2's DNR order been made available to RN K, RN K would not have initiated CPR on Resident 2. Executive Director A stated facility had emergency packets at the front of the building. Executive Director A stated each resident had an emergency packet containing face sheets and advanced directives. Executive Director A stated since the above incident s/he had re-trained staff on the location of the emergency packets. Executive Director A stated s/he labeled all resident emergency packets containing a DNR order with a bright orange sticker. Executive Director A verified Resident 2's DNR had been ordered in fall of 2024. Executive Director A stated since the above incident s/he had reviewed all resident advanced directives and updated code status orders in the EHR.	N 480		