STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510386	A. BUILDING: _____ B. WING _____	R-C 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LACROSSE MC	3161 E AVENUE SOUTH LA CROSSE, WI 54601

(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 08/14/2025, Surveyor conducted a verification visit at Brookdale La Crosse MC. Data collection continued through 08/26/2025. Five deficiencies were identified. Three of the 5 were repeat deficiencies. See Statement of Deficiency (SOD) QBW11, dated 01/08/2025 and SOD MEHB11, dated 10/25/2022. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 26	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation occurred when a resident had an injury that was not observed and could not be adequately explained by the resident. Resident 3 suffered an unwitnessed fall that resulted in hip displacement. Resident 3 was sent to the hospital emergency room (ER) for assessment.	N 161		

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

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N 161	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) MEHB11, dated 10/25/2022. Findings include: On 08/14/2025, at approximately 12:50 PM, Surveyor interviewed Executive Director (ED) A and ED B. When asked if the provider had conducted any recent investigations related to resident injuries, ED A stated they had not. ED A stated falls would be investigated. On 08/20/2025, Surveyor emailed ED A and ED B to request records for Resident 3. At 3:46 PM, Surveyor received a fax from the provider with Resident 3's records. Resident 3 was admitted on 04/18/2024 and had a power of attorney for health care (POAHC) and had multiple diagnoses, including unspecified dementia. A document titled, "Wisconsin Individual Service Plan (ISP)" updated on 07/17/2025, included a handwritten sentence next to a section related to Resident 3's physical disabilities. The sentence read, "Unsteady gait/ambulation post fall with Rt (right) hip displacement, declines to stay in wc (wheelchair.)" Resident 3's observation notes included the following: 08/18/2025: "Observed resident with staples in situ (in place) post right hip dislocation early July ..." 08/14/2025: "Observed resident with Aspirin order	N 161		

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N 161	Continued From page 2 twice daily post hospitalization post fall with hip fracture ..." On 08/26/2025, at 1:00 PM, Surveyor interviewed ED A and ED B via Zoom meeting. When asked about any recent or pending investigations, ED A stated there were no pending investigations and the provider had only conducted one recent investigation related to Resident 1's medications. ED A stated there were no recent investigations related to resident injuries and there were no reportable incidents. When asked about Resident 3's records referencing a fall with hip displacement, ED A stated s/he did not have the exact dates, but s/he knew Resident 3 fell in his/her room and yelled for staff assistance. ED A stated the fall was unwitnessed. ED A stated Resident 3 was up walking around approximately 3 minutes after the fall but later that afternoon s/he was complaining of pain and was sent to the ER. ED A stated it was discovered in the ER that Resident 3 had a non-displaced fracture. ED A stated s/he did not know if Resident 3 was admitted but the ER did keep Resident 3 overnight. ED A stated it was determined the hip was displaced during that fall because staff observed it looking "funky" afterwards. ED A stated Resident 3 did not communicate well. When asked if an incident report and investigation was conducted, ED A stated it was. ED B stated s/he would send it to Surveyor by the end of the day. As of 09/02/2025, Surveyor had not received any further documentation from the provider related to Resident 3's injuries or evidence that an investigation occurred. Cross Reference N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury	N 161		

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N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after Resident 3 received treatment at the emergency room (ER) after falling. This is a repeat deficiency. See Statement of Deficiency (SOD) MEHB11, dated 10/25/2022. Findings include: On 08/20/2025, Surveyor emailed Executive Director (ED) A and ED B to request records for Resident 3. At 3:46 PM, Surveyor received a fax from the provider with Resident 3's records. Resident 3 was admitted on 04/18/2024 and had a power of attorney for health care (POAHC), and had multiple diagnoses, including unspecified dementia. Resident 3's observation notes included the following: 08/18/2025: "Observed resident with staples in situ (in place) post right hip dislocation early July	N 165		

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N 165	Continued From page 4 ..." On 08/26/2025, at 1:00 PM, Surveyor interviewed ED A and ED B via Zoom meeting. When asked if the provider reported Resident 3's incident resulting in injury, ED A stated s/he thought so, and the nurse was doing the reports at that time. ED A stated s/he would need to verify that. Surveyor requested evidence that the provider reported the incident to the department. ED A stated they would send the requested information by the end of the day. On 09/02/2025, Surveyor reviewed the department's e-file for the provider and it did not contain a self-report for Resident 3's fall. As of 11:12 AM, Surveyor had not received any additional documentation from the provider to verify a self-report was submitted to the department. Cross Reference N0161 DHS 83.12(3) Investigate Injuries of Unknown Source	N 165		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received all	{N 352}		

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{N 352}	Continued From page 5 medications in the dosages and at intervals prescribed by a practitioner. Resident 1's scheduled Diltiazem medication was not administered between 07/22/2025 and 08/02/2025. Resident 3's scheduled Famotidine medication was not administered between 07/18/2025 and 08/20/2025. The provider did not have a designated medication passer in the building on the evening of 07/17/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) QBW11, dated 01/08/2025. Findings include: The provider is licensed to care for 33 residents in the client groups of irreversible dementia/Alzheimer's disease, and advanced aged. On 08/14/2025, at approximately 12:50 PM, Surveyor interviewed Executive Director (ED) A and ED B. When asked about the provider's current medication practices, ED A stated they had done a lot of staff education. ED B stated they did regular audits to ensure they were complying. ED A stated they did incident reports for medication errors and there had not been any significant medication errors recently. ED A stated the provider had a corporate nurse on staff that assisted with audits and completing medication incident reports. Surveyor requested all medication error reports completed since May 2025.	{N 352}		

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{N 352}	Continued From page 6 Example 1 At approximately 1:20 PM, Surveyor interviewed Registered Nurse (RN) C. RN C stated s/he was on the medication error committee and medication errors were a hot topic. RN C stated the main concern with the provider was missed medications related to the time frame it took for the pharmacy to get medications. RN C described a scenario in which the pharmacy noticed a resident's prescription had expired and the medications were covered by hospice. RN C stated there was a delay on the part of the provider in catching that the prescription had expired. RN C stated some medications were missed because of that and there needed to be better communication with all parties. RN C stated s/he had just completed an investigation involving Resident 1's missed medications. RN C stated Resident 1 recently passed away on 08/07/2025. RN C stated s/he validated the medication was not on site and requested it right away. RN C stated the provider needed help with medications and the lack of clinical supervision may be a contributing factor. RN C stated staff had more accountability when there was a nurse on site. Surveyor requested a copy of that investigation along with Resident 1's medication administration record (MAR.) At approximately 1:45 PM, Surveyor reviewed Resident 1's July 2025 and August 2025 MAR with RN C. RN C stated that a "20" entered on the MAR would indicate the medication was not administered. RN C stated the last medication cycle ended on 07/21/2025 and Resident 1's medication was not refilled on the new cycle. RN C stated Resident 1 resumed his/her afternoon dose of the medication on 08/02/2025.	{N 352}		

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{N 352}	Continued From page 7 Resident 1 was admitted on 05/27/2022 and had multiple diagnoses, including essential hypertension. Resident 1's July 2025 MAR included the following: Diltiazem HCl Oral Tablet 60 MG. Give 1 tablet by mouth four times a day related to chronic ischemic heart disease, unspecified. The medication was scheduled at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. 07/17/2025 at 4:00 PM and 8:00 PM: blank space 07/22/2025 at 12:00 PM: a "20" was entered. 07/23/2025 at 12:00 PM: "20" 07/24/025 at 8:00 AM, 12:00 PM, 4:00 PM: "20" 07/25/2025 at 8:00 AM, 12:00 PM, 4:00 PM: "20" 07/26/20205 at 8:00 AM, 12:00 PM: "20" 07/27/20205 at 8:00 AM, 12:00 PM: "20" 07/28/2025 at 8:00 AM, 12:00 PM: "20" 07/29/2025 at 12:00 PM: "20" 07/30/2025 at 8:00 AM, 12:00 PM: "20" 07/31/2025 at 12:00 PM, 8:00 PM: "20" Resident 1's August 2025 MAR included the following: 08/01/2025 at 12:00 PM: "20" 08/02/2025 at 8:00 AM, 12:00 PM: "20" 08/02/2025 at 8:00 PM: Signed as administered. At approximately 2:00 PM, Surveyor asked RN C to explain the inconsistencies on the MAR and how it was signed as administered some days when it was not refilled with the new cycle. RN C stated there was no way to validate that, but it was possible staff utilized medication from the old cycle. Example 2 On 08/19/2025, Surveyor reviewed a fax sent by	{N 352}		

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{N 352}	Continued From page 8 the provider, including a document titled, "Incident Log," with an incident nature description of, "Medication." The log included the names of 24 residents and identified they did not receive their medications on the evening shift of 07/17/2025 because there was not a staff member available that was authorized to pass medications. Example 3 On 08/20/2025, Surveyor emailed ED A and ED B to request records for Resident 3. At 3:46 PM, Surveyor received a fax from the provider with Resident 3's records. Resident 3 was admitted on 04/18/2024 and had a power of attorney for health care (POAHC). Staff observation notes showed multiple entries identifying Famotidine Oral Tablet 20 MG was "waiting for refill." Resident 2's August 2025 MAR included the following: Famotidine Oral Table 20 MG. Give 1 tablet by mouth one time a day for indigestion. Start date 07/18/2025. A "20" was entered on 17 of 20 days in August. The chart code indicated a 20 meant "Medication/Treatment Not Available/Pharmacy Action." On 08/22/2025, the department received a self-report from the provider, with an incident date of 08/20/2025. The report indicated that upon review of Resident 3's progress notes, it was discovered Resident 3's Famotidine 20 MG was "waiting for refill." It read, in part, "Further discovery revealed that this medication had been a new order for the resident upon return from the hospital on 7/18/25, however it was never received from the pharmacy..." Under the Incident	{N 352}		

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{N 352}	Continued From page 9 Outcome section, it read, "The resdient [sic] did not receive 34 doses of the prescribed medication from 7/18/25 to 8/20/25." On 08/26/2025, at 1:00 PM, Surveyor interviewed ED A and ED B via Zoom meeting. When asked about Resident 3's Famotidine medication, ED B stated that after speaking with the nurse, it was discovered there were 3 medications ordered following Resident 3's appointment. ED B stated s/he overlooked the Famotidine medication. ED B stated they were working to ensure the issues were addressed. The provider did not ensure residents received all medications in the dosages and at intervals prescribed by a practitioner. Resident 1 and Resident 3 had medications waiting to be refilled by the pharmacy, resulting in multiple missed medications. The provider did not have a medication passer on the evening shift on 07/17/2025, resulting in approximately 23 residents not receiving their medications. Cross Reference N0396 83.36(1)(a) Adequate Staff To Meet Resident Needs Cross Reference N0415 83.37(2)(d) Documentation of Medication Administration	{N 352}		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the	N 396		

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N 396	Continued From page 10	N 396		

provider did not ensure employees were provided in sufficient numbers on a 24-hour basis to meet resident needs. On 07/17/2025, the provider did not have a staff member to pass medications.

Findings include:

The provider is licensed to care for 33 residents in the client groups of irreversible dementia/Alzheimer's disease, and advanced aged.

On 08/14/2025, Surveyor requested all medication error reports completed since May 2025, from Executive Director (ED) A and ED B.

On 08/19/2025, Surveyor reviewed a fax sent by the provider, including a document titled, "Incident Log," with an incident nature description of, "Medication." The log included the names of 24 residents and identified they did not receive their medications on the evening shift on 07/17/2025. The following was reported on the log:

Resident 2 was on the incident log and under an "Additional Facts/Not Referenced Above" section, with an incident date of 07/31/2025, it read, "Reported to this writer by private caregiver upon return from urgent care that resident was reported [s/he] has not being [sic] receiving morning and night medications. Writer checked medication administration report, noted no medications missed except for July 17, 2025, which was accounted for as not having med (medication) tech (technician) on evening shift, POAs (Power of Attorneys) aware ..."

Resident 2 had another entry with an incident date of 07/17/2025 that read, "This writer met by resident's private caregiver, states [s/he] spend

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N 396	Continued From page 11 [sic] 10 hours with resident out on Thursday, July 17, 2025, [sic] upon returning to the community, [s/he] checked in with [Provider] and asked who the med tech on duty was, [sic] [Provider] reported there was no med tech on the floor, called leadership twice, left voice message, reported to this writer resident did not get scheduled medications on overnight and did not sleep per private caregiver, states resident's [Family Member] expressed concerns ..." On 08/26/2025, at 1:00 PM, Surveyor interviewed ED A and ED B via Zoom meeting. When asked if the provider had a staff authorized to pass medications on the evening of 07/17/2025, ED B stated they did not and they had a staffing issue that day. ED B stated they missed quite a few medications. ED B stated they had a medication passer next door scheduled to come over at 4:00 PM and that person failed to come over and did not notify anyone. ED A stated that person was no longer employed with the provider. Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 396		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any	N 415		

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N 415	Continued From page 12 PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3 had their medication administration accurately documented. Resident 3's Famotidine 20 MG was documented as administered at times the medication was unavailable for administration. Findings include: On 08/20/2025, Surveyor emailed Executive Director (ED) A and ED B to request records for Resident 3. At 3:46 PM, Surveyor received a fax from the provider with Resident 3's records. Resident 3 was admitted on 04/18/2024 and had a power of attorney for health care (POAHC). Staff observation notes showed multiple entries identifying Famotidine Oral Tablet 20 MG was "waiting for refill." Resident 3's August 2025 MAR included the following: Famotidine Oral Table 20 MG. Give 1 tablet by mouth one time a day for indigestion. Start date 07/18/2025. A "20" was entered on 17 of 20 days in August. The chart code indicated a 20 meant "Medication/Treatment Not Available/Pharmacy Action." The medication included a check mark and appeared to be signed as administered on 08/05/2025, 08/07/2025, and 08/12/2025. On 08/26/2025, at 1:00 PM, Surveyor interviewed ED A and ED B via Zoom meeting. When asked if	N 415		

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N 415	Continued From page 13 Resident 3's Famotidine was available for administration prior to 08/20/2025, ED B stated it was not. ED B stated that was a documentation issue and both staff that signed the medication as administered were spoken to. ED B stated both staff admitted to making an error in the documentation. Cross Reference N0352 83.32(3)(h) Rights of Residents: Receive Medication	N 415		