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 03/10/2026

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 02/26/2026, Surveyor conducted a standard survey, verification visit, self report survey, and 2 complaint investigations at Brookdale Lacrosse MC. Data collection continued through 03/10/2026. Both complaints were substantiated. Eight deficiencies were identified. Three of the 8 deficiencies were repeat violations. See Statement of Deficiency (SOD) QBW11, dated 01/08/2025, SOD QBW12, dated 08/26/2025 and SOD HPA711, dated 12/13/2022. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 24	{N 000}		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	N 220		

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

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 03/10/2026

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 220	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed (Caregiver B, Caregiver F, and Caregiver G) were screened for communicable disease by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse. Findings include: On 02/26/2026, Surveyor conducted a standard survey and reviewed employee files for Caregiver B, Caregiver F and Caregiver G. Surveyor reviewed Caregiver B's employee record and noted s/he was hired on 03/12/2025. There was no evidence in Caregiver B's record s/he was screened for communicable disease. Surveyor reviewed Caregiver F's employee record and noted s/he was hired on 01/27/2025. There was no evidence in Caregiver F's record s/he was screened for communicable disease. Surveyor reviewed Caregiver G's employee record and noted s/he was hired on 11/06/2025. There was no evidence in Caregiver G's record s/he was screened for communicable disease. On 03/10/2026, at 11:00 AM, Surveyor interviewed Health Director (HD) A, Operations Specialist (OS) C, Nurse H, and OS I via phone. OS I stated health screens were conducted as part of the hiring process. OS C stated s/he believed the above caregivers had TB results in their files. OS I stated s/he would check to see if those records were kept elsewhere and would submit them to Surveyor via email.	N 220		

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 03/10/2026

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 220	Continued From page 2 At 11:37 AM, Surveyor sent an email to OS I with a written request to provide any additional information within 2 hours. As of 3:46 PM, Surveyor had not received any additional information related to the employee health screens.	N 220		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 staff (Caregiver E) received at least 15 hours of continuing education per calendar year which included standard precautions, resident rights, and preventing and reporting of abuse, neglect and misappropriation. Caregiver E did not have any documented training hours in 2025. Findings include:	N 277		

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 03/10/2026

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 277	Continued From page 3 On 02/26/2026, at 2:48 PM, Surveyor reviewed Caregiver E's staff file provided by Health Director (HD) A. Caregiver E was hired on 05/08/2023. Caregiver E's record did not contain 15 hours of continuing education in 2025 including education in standard precautions, resident rights, and preventing and reporting of abuse, neglect and misappropriation. On 03/10/2026, at 11:00 AM, Surveyor interviewed HD A, Operations Specialist (OS) C, Nurse H, and OS I via phone. When asked about Caregiver E's continuing education received in 2025, OS I stated s/he could not speak to that. At 11:37 AM, Surveyor sent an email to OS I with a written request to provide any additional information within 2 hours. As of 3:47 PM, Surveyor had not received any additional information related to Caregiver E's continuing education received in 2025.	N 277		
{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 medications in the dosages and at intervals prescribed by a practitioner.	{N 352}		

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 03/10/2026

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 352}	Continued From page 4 Resident 1 did not receive 10 doses of his/her scheduled Isoniazid medication. Resident 2 did not receive his/her scheduled Melatonin and Amlodipine medication. Resident 3 did not receive his/her scheduled Senna medication on 02/26/2026. This is a repeat deficiency. See Statement of Deficiency (SOD) QBW11, dated 01/08/2025 and SOD QBW12, dated 08/26/2025. 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 10/27/2025, the department received a complaint alleging resident's medications were not available to administer. On 11/17/2025, the department received a self-report that read, in part, "On 11/10/25 it was realized that prophylactic medication Isoniazid had not been consistently administered as prescribed." The report identified Resident 1 as not receiving the scheduled medication and Resident 1 was sent to the emergency room (ER) for further evaluation. Example 1 On 02/26/2026, at approximately 3:30 PM, Surveyor interviewed Health Director (HD) A. When asked about the self-report submitted to the department involving Resident 1, HD A stated	{N 352}		

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 03/10/2026

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 352}	Continued From page 5 s/he was not exactly sure what happened but was aware Resident 1 went without his/her medication for a period of time. Resident 1 was admitted on 10/03/2025 and had multiple diagnoses, including latent tuberculosis. Resident 1's November 2025 Medication Administration Record (MAR) included the following: Isoniazid Oral Tablet 300 MG. Give 1 tablet by mouth one time a day to prevent active tuberculosis infection. Take 1 tablet (400mg) by mouth in the morning. The medication was scheduled at 8:00 AM. A staff progress note, dated 11/10/2025, indicated Resident 1 missed 10 doses of his/her Isoniazid medication. Example 2 Resident 2 was admitted on 07/23/2022 and had multiple diagnoses, including essential hypertension and insomnia. Resident 2's September 2025 MAR included the following: Amlodipine Besylate Tablet. 5 MG. Give 1 tablet by mouth one time a day related to essential (primary) hypertension. Take 1 tablet once daily for high blood pressure. On 09/07/2025, there was a "20" code entered in the designated space. The key code on the MAR identified 20 as meaning, "Medication/Treatment Not Available/Pharmacy Action." Melatonin Tablet. 3 MG. Give 1 capsule by mouth at bedtime for sleep. On 09/06/2025 and 09/07/2025, there was an "18" code entered in the designated space. The key code on the MAR	{N 352}		

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 03/10/2026

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 352}	Continued From page 6 identified 18 as meaning, "Other/See Med (Medication) Note." A staff progress note, dated 09/06/2025, indicated the Melatonin medication was "Not available." On 09/07/2025, a progress note indicated the medication was, "not in cart." A staff progress note, dated 09/06/2025, included the following regarding the Amlodipine medication: "Last pill given today. None on hand. Needs ordered [sic]." A progress note, dated 09/07/2025, indicated the Amlodipine medication was "out, last dose given 9/6." Example 3 Resident 3 was admitted on 04/18/2024 and had multiple diagnoses including constipation. On 02/26/2025, at approximately 3:45 PM, Surveyor observed the medication cart along with Health Director (HD) A. Surveyor requested to review Resident 3's bubble pack medications. Surveyor and HD A noticed Resident 3 had a pill still in the pack that was scheduled for 8:00 AM that morning. HD A indicated it was Resident 3's scheduled Senna medication. When asked what the protocol was when a medication was not administered as scheduled, HD A stated s/he would provide re-education to staff, call Resident 3's provider, and let Resident 3's guardian know of the missed medication. The provider did not ensure residents received all medications in the dosages and at intervals prescribed by a practitioner when Resident 1, Resident 2, and Resident 3 missed scheduled doses of their medications.	{N 352}		

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 03/10/2026

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 352}	Continued From page 7 Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration	{N 352}		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review, and interview, the provider did not ensure individual service plans (ISP) included all required components for 2 of 3 residents reviewed (Resident 1 and Resident 3). Resident 1 and Resident 3's ISP did not include desired outcomes, measurable goals, methods for delivering care, who was responsible for delivering the care, and the frequency for the needed care. Findings include: On 02/26/2026, Surveyor reviewed records for	N 386		

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 03/10/2026

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 386	Continued From page 8 Resident 1 and Resident 3. Example 1 Resident 1 was admitted on 10/03/2025 and had multiple diagnoses including Type 2 diabetes mellitus, hyperlipidemia, vascular dementia, major depressive disorder, essential hypertension, and chronic kidney disease. A document titled, "Wisconsin Individual Service Plan (ISP)" with a "Date of Original ISP" of 10/03/2025 was included in the record. Fine print underneath the heading read, "To be completed within 30 days of move in, updated every 6 months thereafter or more when indicated by a change in the resident's condition." It appeared to be a 1-page document with the body of the document having the following sections: Oral Health: "None noted at this time." Risk for Choking: "None." Physical Disabilities: "Utilizes walker with ambulation." Mental/Emotional Health: "Diagnosis of vascular dementia with other comorbidities." There was a separate section titled, "Nursing Care" with a box checked, "Yes." The document did not identify measurable goals, desired outcomes and specific methods for delivering care and the frequency for needed care. The area for the resident or guardian to sign was blank. The legal representative area was also blank. At approximately 3:00 PM, Surveyor interviewed Health Director (HD) A. When asked if the above document was considered Resident 1's comprehensive ISP, HD A stated s/he was not	N 386		

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 03/10/2026

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 386	Continued From page 9	N 386		

sure and was not aware if a different ISP was created within 30 days.

Example 2

Resident 3 was admitted on 04/18/2024 and had multiple diagnoses including unspecified dementia, psychotic disturbance, mood disturbance and anxiety, chronic kidney disease, essential hypertension, hyperlipidemia and major depressive disorder.

A document titled, "Wisconsin Individual Service Plan (ISP)" with a "Date of Original ISP" of 04/18/2024 was included in the record. Fine print underneath the heading read, "To be completed within 30 days of move in, updated every 6 months thereafter or more when indicated by a change in the resident's condition." It appeared to be a 1-page document with the body of the document having the following sections:

Oral Health: "None noted at this time."
Risk for Choking: "None."
Physical Disabilities: "None."
Mental/Emotional Health: "Diagnosis of unspecified dementia with other comorbidities."
There was a separate section titled, "Nursing Care" with a box checked, "Yes."

The document did not identify measurable goals, desired outcomes and specific methods for delivering care and the frequency for needed care. The area for the resident or guardian to sign was blank. The legal representative area was also blank.

On 03/10/2026, at 11:00 AM, Surveyor interviewed HD A, Operations Specialist (OS) C, Nurse H, and OS I via phone. Surveyor stated the

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 03/10/2026

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 386	Continued From page 10 1 page document that appeared to be the resident's 30 day comprehensive ISP did not include all required information.	N 386		
{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 PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 3 had his/her medication administration accurately documented. Resident 3's Sennosides-Docusate Tablet was documented as administered when it was observed left in the medication packaging. The provider's annual medication review identified multiple inconsistencies on written medication orders. This is a repeat deficiency. See Statement of Deficiency (SOD) QBW112, 08/26/2025 Findings include:	{N 415}		

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 03/10/2026

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 415}	Continued From page 11 Example 1 On 02/26/2025, at approximately 3:45 PM, Surveyor observed the medication cart along with Health Director (HD) A. Surveyor requested to review Resident 3's bubble pack medications. Surveyor and HD A noticed Resident 3 had a pill left in the packaging that was scheduled for 8:00 AM that morning. HD A indicated it was Resident 3's scheduled Senna medication, and the medication appeared to be half punched out. When asked if the medication had been signed as administered, HD A checked the provider's electronic medication administration record and stated it was charted as given. HD A indicated s/he would discard the medication. Example 2 On 03/03/2026, Surveyor requested the provider's annual medication review that was conducted by a physician, pharmacist, or registered nurse from HD A via email. At 5:22 PM, Surveyor received the annual medication review via email from HD A that included the following: The heading of the document indicated a review date of "December 30, 2025 through December 31, 2025." It appeared to be completed by a pharmacy and did not include a signature. Resident 3 had the following comments on the report: "[Resident 3's] order Mirtazapine 15 mg tablets in PCC (Point Click Care) says to give 1 tab po q HS (orally every night at bedtime,) then in the additional directions it says to give 1/2 tab po q HS. Which is correct?" Recommendations read, "Please clarify/update the directions with	{N 415}		

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 03/10/2026

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 415}	Continued From page 12 one specific dose to give." Resident 5 had the following comments on the report: "[Resident 5's] order for Donepezil in PCC has the main directions saying to give it in the AM (morning) but the additional directions saying to give it q HS (bedtime.) The recommendations read, "Recommend clarifying the main directions to say give a HS and adjust the administration time accordingly." Resident 6 had the following comments on the report: "[Resident 6's] Lorazepam PRN (as needed) order says to give 0.25 mL as the dose in one place and to give 0.35mL as the dose in another place. Was the 0.35 a mistake?" The recommendations read, "Please clarify/correct." Resident 7 had the following comments on the report: "[Resident 7's] order for Morphine in PCC was entered as the 20mg/5mL product but the directions say to give 0.25mL (5mg), which would correspond to the 20mg/1mL concentrate." The recommendations read, "Please clarify/correct so the concentration of the product entered in PCC matches the directions and medication sent from the pharmacy." On 03/10/2026, at 11:00 AM, Surveyor interviewed HD A, Operations Specialist (OS) C, Nurse H, and OS I via phone. When asked about the discrepancies identified on the annual medication review, HD A stated s/he did not see the discrepancies until they pulled it upon Surveyor's request. HD A stated s/he would look into it and see what s/he could do. The provider did not ensure Resident 3 had his/her medication administration accurately documented when staff charted a medication as	{N 415}		

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 03/10/2026

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 415}	Continued From page 13 administered when it was not. The medication had been left in the packaging and was discarded. The provider did not ensure accurate medication documentation as there were multiple inconsistencies identified on the provider's annual medication review. Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	{N 415}		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide an environment that was safe, clean, comfortable, and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) HPA711, dated 12/13/2022. 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 01/08/2026, the department received a complaint alleging there was mold, water damage, and areas in need of repair in the	N 481		

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 03/10/2026

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 481	Continued From page 14 building. On 02/26/2026, at approximately 12:15 PM, Surveyor interviewed Health Director (HD) A and Operations Specialist (OS) C. When asked about any maintenance issues in the building, HD A stated staff had expressed concerns about some odors in the kitchen area. HD A stated maintenance staff went to look at it. OS C stated there was no more odor and if there had been water, it was taken care of. At approximately 1:15 PM, Surveyor interviewed Caregiver B. When asked about any maintenance issues in the building, Caregiver B stated there was mold all over the kitchen. Caregiver B stated there was water damage in the front near the dishwasher. At approximately 2:47 PM, Surveyor interviewed OS C. OS C stated there had been a leak under the sink and a dehumidifier was purchased for the main kitchen. OS C stated there had been mildew but not mold. At 4:19 PM, Surveyor observed the main kitchen area. The baseboard along the floor, to the right of the dishwasher, had chipped paint, exposed wood, and black discoloration. The cabinet above that area had a baseboard appearing warped and had chipped paint. The opposite side of the cabinet which faced the dining area had paneling that was bending and was wrinkled in appearance. At approximately 4:20 PM, Surveyor asked Caregiver D how long the cabinet was in the current condition. Caregiver D stated it had been like that since s/he got there in December. Caregiver D stated the provider had issues with	N 481		

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 03/10/2026

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 481	Continued From page 15 the dishwasher. The provider did not provide an environment that was safe, clean, comfortable, and homelike when the kitchen area displayed cabinet areas that were not well maintained and presented with what appeared to be water damage.	N 481		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct quarterly fire drills (including at least one fire evacuation drill simulating the conditions during usual sleeping hours) with both employees and residents in 2025. Documentation did not include record of residents having an evacuation time greater than	N 525		

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 03/10/2026

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 525	Continued From page 16 the time allowed under DHS 83.35(5), and the type of assistance needed for evacuation. Findings include: On 02/26/2026, Surveyor reviewed the provider's safety records provided by Operations Specialist (OS) C that included the following: A packet of documents, titled, "Fire Drills Jan (January) 2025 - Jan 2026." It read, in part, "Fire Drills are performed at least once per shift per quarter totaling at least 12 drills in a 12-month period. Drills are scheduled monthly at varying times in order to give staff experience under different conditions ..." The logbook documentation did not include evidence of resident participation in any of the fire drills conducted. There were two columns that allowed for signatures, titled, "Residents Participating" and "Associates Participating." The "Residents Participating" was blank aside from 2 signatures that appeared to be signed by a staff member. There was a section on each of the logbook entries titled, "Remarks of Person Holding Drill." On the following dates, it read, "Needs improvement:" 01/31/2025, 02/19/2025, 03/25/2025, 04/30/2025, 05/31/2025, 06/26/2025, 07/31/2025, 08/31/2025, 09/18/2025, 10/30/2025, 11/28/2025, and 12/30/2025. On 03/10/2026, at 11:00 AM, Surveyor interviewed Health Director (HD) A, Operations Specialist (OS) C, Nurse H, and OS I via phone. OS I stated residents should be participating in the fire drills. Surveyor stated s/he did not see evidence of resident participation on the documentation provided. OS I stated s/he would check into it.	N 525		

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 03/10/2026

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 525	Continued From page 17 At 11:37 AM, Surveyor sent an email to OS I with a written request to provide any additional information within 2 hours. As of 3:47 PM, Surveyor had not received any additional information related to fire drills.	N 525		
N 558	83.48(8)(b) Sprinkler system installation and maintenance Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the sprinkler system was maintained. The provider did not complete follow up of deficiencies identified during the sprinkler inspection on 06/10/2025. Findings include: On 02/26/2026, Surveyor reviewed the provider's documentation of environmental records. Records indicated the provider's most recent sprinkler system inspection was completed on 06/10/2025 with the following deficiencies	N 558		

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 03/10/2026

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 558	Continued From page 18 identified: -Dry Valve. "Date of last successful system air leakage test? 2021-07-13." Under a "Deficiency Authority" section, it read, in part, "Dry pipe systems shall be tested once every three years for air leakage, using one of the following text methods ..." -Sprinkler Questions. "Dry sprinklers replaced or successfully sample tested within last 10 years?" The answer next to the question was no. Under a "Deficiency Authority" section, it read, "Dry sprinklers that have been in service for 10 years shall be replaced, or representative samples shall be tested and then retested at 10-year intervals." Under a "Technician Comments" section, it read, "[Agency] will be contacting you shortly to discuss how we may help you create an action plan to correct deficiencies identified in this inspection." On 03/10/2026, at 11:00 AM, Surveyor interviewed Health Director (HD) A, Operations Specialist (OS) C, Nurse H, and OS I via phone. Surveyor discussed the deficiencies identified on the inspection and asked if they had been corrected. OS I stated s/he would have to look into it. At 11:37 AM, Surveyor sent an email to OS I with a written request to provide any additional information within 2 hours. As of 3:48 PM, Surveyor had not received any additional information related to the sprinkler inspection.	N 558		