STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017799	A. BUILDING: _____ B. WING _____	R-C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBERGE AT BROOKFIELD A MEMORY CARE COMM	1105 DAVIDSON RD BROOKFIELD, WI 53045

(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 01/22/2025, the Bureau of Assisted Living, Southern Regional Office conducted a verification visit of statement of deficiency (SOD) RRPX11 at Auberge At Brookfield Memory Care Community, located at 1105 Davidson Rd in Brookfield, WI. One repeat citation of noncompliance was issued. Census: 53 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 3, Resident 4, and Resident 5 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Based on Resident 3's daily lidocaine transdermal patch (pain medication in a topical patch applied to skin) prescription, a 30-day supply of 30 patches originally provided by the pharmacy and the 8 remaining patches in the bag dated 10/08/2024, and the caregiver documentation of approximately 96 patches administered between 10/08/2024 and 01/22/2025, Resident 3 did not	{N 352}		

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

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{N 352}	Continued From page 1	{N 352}		

receive lidocaine transdermal patch administration as prescribed.

Based on Resident 4's daily lidocaine transdermal patch prescription, a 15-day supply of 15 patches originally provided by the pharmacy and the 7 remaining patches in the bag dated 01/03/2025, and the caregiver documentation of approximately 20 patches administered between 01/03/2025 and 01/22/2025, Resident 4 did not receive lidocaine transdermal patch administration as prescribed.

Based on Resident 5's daily lidocaine transdermal patch prescription, a 15-day supply of 15 patches originally provided by the pharmacy and the 12 remaining patches in the bag dated 01/03/2025, and the caregiver documentation of approximately 20 patches administered between 01/03/2025 and 01/22/2025, Resident 5 did not receive lidocaine transdermal patch administration as prescribed.

This requirement is being cited for a fourth time. See Statement of Deficiency (SOD) RRPX11, issued on 10/01/2024, SOD Y77R14, issued 11/28/2023, and SOD Y77R11, issued on 09/01/2022.

The findings include:

Example 1: Resident 3

On 01/22/2025 at approximately 11:15 A.M., Surveyor observed Caregiver F remove a package/clear bag containing 8 lidocaine 5 % transdermal patches from the medication cart. The bag had an affixed pharmacy label including Resident 3's name, the medication name, the

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{N 352}	Continued From page 2 medication prescription with directions for application, the date the prescription was filled by the pharmacy, and the number of patches originally contained within the bag. The label included, "Apply 1 patch topically to left hip area every 24 hours (12 hours on, 12 hours off)." The label included 30 patches were filled by the pharmacy on 10/08/2024. The label included the same prescription as included within the facility's electronic medication administration record (MAR) Caregiver F had displayed on the medication cart's laptop screen. Surveyor observed the last administration of Resident 3's lidocaine patch was documented at 01/22/2025 at 8:43 A.M. Caregiver F told Surveyor Resident 3 often refuses administration of the patch or removes it shortly after administration stating the patch was too cold. On 01/22/2025, Surveyor reviewed Resident 3's record as provided by Facility Nurse B. Resident 3 was admitted to the facility on 05/09/2023 with diagnoses including dementia. Resident 3's MARs from 10/08/2024 (last date of lidocaine 5 % patch delivery from pharmacy) through 01/22/2025 included documentation of approximately 96 applications out of 107 potential doses during that time frame. The 11 doses not administered to Resident 3 during this time frame included documentation of Resident 3's refusals of the medication. Based on Resident 3's lidocaine transdermal patch prescription, a 30-day supply of 30 patches originally provided by the pharmacy and the 8 remaining patches in the bag dated 10/08/2024, and the caregiver documentation of approximately 96 patches administered between 10/08/2024 and 01/22/2025, Resident 3 did not receive lidocaine transdermal patch administration as prescribed.	{N 352}		

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{N 352}	Continued From page 3 On 01/22/2025 at 12:33 P.M., Surveyor conducted an interview with Pharmacist H. Pharmacist H told Surveyor Resident 3's lidocaine 5 % transdermal patch, as prescribed, was last delivered to the facility on 10/08/2024. Pharmacist H told Surveyor 30 patches, as prescribed, were delivered in 1 bag. Pharmacist H told Surveyor the facility must request refills for this medication and the facility had not requested a refill after 10/08/2024. Pharmacist H told Surveyor the only previous delivery of Resident 3's lidocaine 5 % transdermal patch, as prescribed, was delivered to the facility on 08/11/2024 with 30 patches in 1 bag. Example 2: Resident 4 On 01/22/2025 at approximately 11:21 A.M., Surveyor observed Caregiver G remove a package/clear bag containing 7 lidocaine 4 % transdermal patches from the medication cart. The bag had an affixed pharmacy label including Resident 4's name, the medication name, the medication prescription with directions for application, the date the prescription was filled by the pharmacy, and the number of patches originally contained within the bag. The label included, "Apply 1 patch topically once a day to back for pain (12 hours on, 12 hours off) (Remove old patch before applying new patch)." The label included 15 patches were filled by the pharmacy on 01/03/2025. The label included the same prescription as included within the facility's electronic medication administration record (MAR) Caregiver G had displayed on the medication cart's laptop screen. Surveyor observed the last administration of Resident 4's lidocaine patch was documented at 01/22/2025 at 8:24 A.M.	{N 352}		

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{N 352}	Continued From page 4 On 01/22/2025, Surveyor reviewed Resident 4's record as provided by Facility Nurse B. Resident 4 was admitted to the facility on 06/06/2022 with diagnoses including dementia. Resident 4's MAR from 01/03/2025 (last date of lidocaine 4 % patch delivery from pharmacy) through 01/22/2025 included documentation of approximately 20 applications out of 20 potential doses from a 15-day supply during that time frame. Based on Resident 4's lidocaine transdermal patch prescription, a 15-day supply of 15 patches originally provided by the pharmacy and the 7 remaining patches in the bag dated 01/03/2025, and the caregiver documentation of approximately 20 patches administered between 01/03/2025 and 01/22/2025, Resident 3 did not receive lidocaine transdermal patch administration as prescribed. On 01/22/2025 at 12:33 P.M., Surveyor conducted an interview with Pharmacist H. Pharmacist H told Surveyor Resident 4's lidocaine 4 % transdermal patch, as prescribed, was last delivered to the facility on 01/03/2025. Pharmacist H told Surveyor 15 patches, as prescribed, were delivered in 1 bag. Pharmacist H told Surveyor the facility must request refills for this medication and the facility had not requested a refill after 01/03/2025. Pharmacist H told Surveyor the only previous delivery of Resident 4's lidocaine 4 % transdermal patch, as prescribed, was delivered to the facility on 11/24/2024 with 15 patches in 1 bag. Example 3: Resident 5 On 01/22/2025 at approximately 11:30 A.M., Surveyor observed Caregiver G remove a package/clear bag containing 12 lidocaine 4 %	{N 352}		

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transdermal patches from the medication cart. The bag had an affixed pharmacy label including Resident 5's name, the medication name, the medication prescription with directions for application, the date the prescription was filled by the pharmacy, and the number of patches originally contained within the bag. The label included, "Apply 1 patch topically in the morning & [and] remove once daily at bedtime for pain (12 hours on, 12 hours off)." The label included 15 patches were filled by the pharmacy on 01/03/2025. The label included the same prescription as included within the facility's electronic medication administration record (MAR) Caregiver G had displayed on the medication cart's laptop screen. Surveyor observed the last administration of Resident 5's lidocaine patch was documented at 01/22/2025 at 8:59 A.M. Caregiver G told Surveyor s/he had not administered Resident 5's lidocaine patch, as prescribed, at 8:59 A.M. because Resident 5 refused application at that time. Caregiver G said s/he documented Resident 5's patch had been administered at 8:59 A.M. with the intention of approaching Resident 5 at a later time for administration. Caregiver G told Surveyor s/he had not approached Resident 5 for administration as of this observation at 11:30 A.M.

On 01/22/2025, Surveyor reviewed Resident 5's record as provided by Facility Nurse B. Resident 5 was admitted to the facility on 12/20/2022 with diagnoses including dementia. Resident 5's MAR from 01/03/2025 (last date of lidocaine 4 % patch delivery from pharmacy) through 01/22/2025 included documentation of approximately 20 applications out of 20 potential doses from a 15-day supply during that time frame.
Based on Resident 5's lidocaine transdermal patch prescription, a 15-day supply of 15 patches

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{N 352}	Continued From page 6 originally provided by the pharmacy and the 12 remaining patches in the bag dated 01/03/2025, and the caregiver documentation of approximately 20 patches administered between 01/03/2025 and 01/22/2025, Resident 5 did not receive lidocaine transdermal patch administration as prescribed. On 01/22/2025 at 12:33 P.M., Surveyor conducted an interview with Pharmacist H. Pharmacist H told Surveyor Resident 5's lidocaine 4 % transdermal patch, as prescribed, was last delivered to the facility on 01/03/2025. Pharmacist H told Surveyor 15 patches, as prescribed, were delivered in 1 bag. Pharmacist H told Surveyor the facility must request refills for this medication and the facility had not requested a refill after 01/03/2025. Pharmacist H told Surveyor the only previous delivery of Resident 5's lidocaine 4 % transdermal patch, as prescribed, was delivered to the facility on 11/24/2024 with 15 patches in 1 bag. On 01/22/2025 at 12:41 P.M., Surveyor conducted an interview with Facility Nurse B. Facility Nurse B verbally acknowledged Resident 3's, Resident 4's, and Resident 5's transdermal patches could not have been administered as prescribed. Facility Nurse B told Surveyor a transdermal patch was a medication that requires 'an extra step' for administration, unlike oral, pill form medications. Facility Nurse B told Surveyor s/he would be implementing a count sheet for this type of medication administration to improve accountability and make it easier to audit the medication carts for proper medication administration.	{N 352}		