STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018392	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARIA CRESENTIA CBRF	16770 WEST NORTH AVENUE 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 10/01/2025, Surveyor conducted a standard survey at St. Maria Crescentia CBRF. Two deficiencies were identified. Census: 8	N 000		
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 record review and interview, the provider did not ensure the person administering medications documented in the resident record the dosage of all medications taken. Staff did not document number of units of sliding scale insulin administered to Resident 1. Findings include: On 10/01/2025, Surveyor reviewed Resident 1's record. S/he was admitted 09/27/2021. Diagnoses included Type I diabetes.	N 415		

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
	0018392	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARIA CRESENTIA CBRF	16770 WEST NORTH AVENUE 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 415	Continued From page 1 Physician orders included: Novolog Penfill Cart 100 Unit/ML (Insulin Aspart 100 Unit/ML) Inject 9.5 Units subcutaneously before breakfast, 2 Units before lunch, 5.5 Units before dinner plus sliding scale: -(Sliding scale order dated 09/01/2025-09/25/2025 administered at 7:00 AM, Noon and 6:00 PM) Novolog Penfill Cart 100 Unit/ML (Insulin Aspart 100 Unit/ML) Use correction scale of additional 0.5 units/50 If BS >150; 151-200= +0.5 Units, 201-250= +1 Unit; 251-300 = +1.5 Units, 301-350 = +2 Units, 351-400 = +2.5 Units; >400 = +3 Units and call MD. -(Sliding scale order dated 09/26/2025-09/30/2025 administered at 7:00 AM, Noon and 6:00 PM) Novolog Penfill Cart 100 Unit/ML (Insulin Aspart 100 Unit/ML) Use correction scale of additional 0.5 unit/50 if blood sugar (BS) >250; if BS is 250-299 add 0.5 Unit, 300-349 add 1 Unit, 350-399 add 1.5 Units, 400-449 add 2 Units, 450 or greater add 2.5 Units and call MD. -(Sliding scale order dated 09/19/2025-09/20/2025 administered at 3:00 PM and 09/20/2025-09/24/2025 administered at 6:00 PM) Novolog Penfill Cart 100 Unit/ML (Insulin Aspart 100 Unit/ML) Inject 9.5 Units subcutaneously before breakfast, 2 Units before lunch, 5.5 Units before dinner plus sliding scale: If BS is below 100 mg/dl before tube feeding = subtract 1 Unit, if BS is 200-299 = add 0.5 Unit, 300-349 = +1 Unit, 350-399= +1.5 Units, 400-449= + 2 Units, 450 or greater +2.5 and call MD. -(Sliding scale order dated 09/20/2025 administered on 09/20/2025 at 7 AM and 11AM)	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018392	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARIA CRESENTIA CBRF	16770 WEST NORTH AVENUE 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 415	Continued From page 2 Novolog Penfill Cart 100 Unit/ML (Insulin Aspart 100 Unit/ML) Inject 9.5 Units subcutaneously before breakfast, 2 Units before lunch, 5.5 Units before dinner plus sliding scale: If BS is below 100 mg/dl before tube feeding = subtract 1 Unit, if BS is 200-299 = add 0.5 Unit, 300-349 = +1 Unit, 350-399= +1.5 Units, 400-449= + 2 Units, 450 or greater +2.5 and call MD. -(Sliding scale order dated 09/21/2025-09/25/2025 administered at 7 AM, noon and 6 PM) Novolog Penfill Cart 100 Unit/ML (Insulin Aspart 100 Unit/ML) Inject 9.5 Units subcutaneously before breakfast, 2 Units before lunch, 5.5 Units before dinner plus sliding scale: If BS is below 100 mg/dl before tube feeding = subtract 1 Unit, if BS is 200-299 = add 0.5 Unit, 300-349 = +1 Unit, 350-399 = +1.5 Units, 400-449 = + 2 Units, 450 or greater +2.5 and call MD. -(Sliding scale order dated 09/26/2025-09/30/2025 administered at 7:00 AM and noon, and 09/25/2025-09/30/2025 administered at 6:00 PM) Novolog Penfill Cart 100 Unit/ML (Insulin Aspart 100 Unit/ML) Inject 9.5 Units subcutaneously before breakfast, 2 Units before lunch, 5.5 Units before dinner plus sliding scale: If BS is below 100 mg/dl before tube feeding = subtract 1 Unit, if BS is 250-299 = add 0.5 Units, 300-349 = +1 Unit, 350-399 = + 1.5 Unit, 400-499 = +2 Units, 450 or greater = +2.5 Units and call MD. Prime with 2 Units. Medication administration record (MAR) dated 09/01/2025-09/30/2025- Staff did not document number of units of sliding scale insulin administered. On 10/01/2025 at 9:08 AM, Surveyor interviewed	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018392	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARIA CRESENTIA CBRF	16770 WEST NORTH AVENUE 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 415	Continued From page 3 and reviewed Resident 1's September 2025 MAR with Residential Manager A who stated staff did not document the number of units of sliding scale insulin on the MAR or anywhere else. On 10/01/2025 at 12:43 PM, Surveyor discussed concern of medication administration documentation with Residential Manager A, Assistant Manager B, Regional Director C, Director of Regulatory Compliance D, and Case Coordinator E. Case Coordinator E stated the number of units of sliding scale insulin administered needed to be documented on the MAR.	N 415		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018392	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARIA CRESENTIA CBRF	16770 WEST NORTH AVENUE 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 454	Continued From page 4 evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018392	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARIA CRESENTIA CBRF	16770 WEST NORTH AVENUE 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 454	Continued From page 5 the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete medical record was maintained. Resident 2's medical record did not include an admission agreement. Findings include: On 10/01/2025 at approximately 9:00 AM, Surveyor requested Resident 2's record, including the admission agreement. On 10/01/2025 at 10:09 AM, Surveyor received Resident 2's record via email from Case Coordinator E. The record did not include an admission agreement. On 10/01/2025 at approximately 11:45 AM, Case Coordinator E informed Surveyor they could not find Resident 2's admission agreement. On 10/01/2025 at 12:43 PM, Surveyor discussed concern of incomplete medical record with Residential Manager A, Assistant Manager B, Regional Director C, Director of Regulatory Compliance D, and Case Coordinator E. Case Coordinator E stated they would continue searching for it and submit it to Surveyor by noon on 10/02/2025. As of 9:00 AM on 10/03/2025, Surveyor had not received Resident 2's admission agreement.	N 454		