STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013589	A. BUILDING: _____ B. WING _____	R-C 01/07/2025

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BROOKDALE BROOKFIELD AL	660 WOELFEL ROAD BROOKFIELD, WI 53045

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{N 000}	Initial Comments On 01/07/2025, Surveyors conducted 1 verification visit, 1 complaint investigation, and a standard survey. Five deficiencies were identified. Two of 5 deficiencies were repeat violations. See Statement Of Deficiency (SOD) Z21G12 dated 06/21/2023 and Z21G13 dated 11/13/2023. Two of 2 deficiencies from SOD Z21G15, dated 08/13/2024 were corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 65	{N 000}		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12.	N 219		

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

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This Rule is not met as evidenced by:
Based on record review and interview the provider did not ensure caregiver background checks for 2 of 2 caregivers were conducted every four years. The facility could not provide four-year background checks for Caregiver EE and Caregiver FF following the procedures in S.50.065, Stats., and ch. DHS 12.

Findings include:

On 01/07/2025 at approximately 9:30 a.m., Surveyors requested Caregiver EE and Caregiver FF's employee records to include background checks from Executive Director A.
According to The Wisconsin Caregiver Program Manual (P-00038), a complete Caregiver Background Check, at minimum, consists of:

1) A completed DHS form F-82064, Background Information Disclosure (BID).
2) A response from the Department of Justice (DOJ).
3) A Governmental Findings Report from DHS that reports the person's status, including administrative finding or licensing restrictions (IBIS).

On 01/07/2025 at approximately 12:30 p.m., surveyors reviewed and documented the following:

-Caregiver EE was hired on 09/26/20218. Caregiver EE's record included a BID, dated 08/28/2018, DOJ, dated 09/04/2018, and IBIS, dated 09/04/20218. Surveyor noted the four-year background check was due in 09/2022. Caregiver EE 's record did not include an updated BID,

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N 219	Continued From page 2 DOJ, or IBIS. - Caregiver FF was hired on 11/28/2018. Caregiver FF's record included a BID, dated 11/19/2018, DOJ, dated 11/20/2018, and IBIS, dated 11/20/2018. Surveyor noted the four-year background check was due in 11/2022. Caregiver FF 's record did not include an updated BID, DOJ, or IBIS. On 01/07/2025 at approximately 2:30 p.m., Surveyors interviewed Business Office Manager GG and Executive Director A. Surveyors stated they were unable to locate four-year background documentation for Caregiver EE and Caregiver FF. Executive Director A stated that the new Business Office Manager was hired in 2022 and did not know about conducting the four-year background checks. Executive Director A acknowledged the four-year background checks were missing from the employee files.	N 219		
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, record review and interview, the provider did not ensure the resident right to receive all prescribed medications in the dosage and intervals as prescribed by the practitioner for 3 of 4 residents reviewed.	N 352		

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N 352	Continued From page 3 From 03/18/2024 to 01/07/2025, pharmacy dispensed 1 bottle of polyethylene glycol containing 14 doses for Resident 19. One dose was to be administered daily. On 01/07/2025, the bottle was half full despite staff documenting administration of 269 doses from 04/01/2024 - 01/07/2025. From 12/05/2024 to 01/07/2025, there were 5 discrepancies between staff's administration/holding of Resident 21's metoprolol and the blood pressure and pulse values as indicated in his/her prescription hold parameters. From 12/01/2024-01/07/2025, there was 4 occurrences, Resident 22 did not receive his/her eye drops as prescribed due to the medications not being available. This is a repeat deficiency. See Statement of Deficiency (SOD) Z21G12 dated 06/21/2023. Findings include: On 09/09/2024, the Department received a complaint regarding medications. The facility is licensed as a CLASS CNA (nonambulatory) CBRF able to serve up to 95 residents within the client groups of irreversible dementia/Alzheimer's, advanced age and physically disabled. Example 1- Resident 19 On 01/07/2025 at 10:23 AM, Surveyor inspected medication cart #2 with Med Tech DD. Surveyor observed a bottle of Resident 19's polyethylene	N 352		

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glycol powder in the medication cart.
Manufacturer's label identified: "8.3 OZ (238 grams) 14 Once-Daily Doses".
Pharmacy labeled identified:
Resident 19
Mix 17 grams in 4-8 OZ of liquid, stir well, and drink once daily.
Dispense Date: 03/18/2024, and 1 of 1 bottle(s) dispensed. (Photos 1 and 2).

There were no additional bottles of polyethylene glycol powder in the medication cart for Resident 19.

On 01/07/2025 at 10:23 AM, Surveyor interviewed Med Tech DD. Med Tech DD examined Resident 19's bottle of polyethylene glycol dispensed 03/18/2024 and stated s/he agreed with Surveyor that the bottle was a little over half full. Med Tech DD stated s/he had not yet administered it to Resident 19 on 01/07/2025 because s/he took it after breakfast. Med Tech DD stated s/he would be administering it from the bottle dispensed 03/18/2024. Med Tech DD checked Resident 19's medication administration record (MAR) and verified 1 dose was to be administered daily.

On 01/07/2025 at 11:50 AM, Surveyor interviewed Health and Wellness Director CC who stated s/he called pharmacy on 01/07/2025 and was informed Resident 19's polyethylene glycol was last dispensed in March 2024.

On 01/07/2025, Surveyor reviewed Resident 19's record. S/he was admitted 12/07/2022.
Physician orders included polyethylene glycol 3350 Powder give 17 grams once daily for constipation. Mix with 8 ounces of preferred beverage. Start date 03/09/2024.

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N 352	Continued From page 5 MAR dated 12/01/2024-01/07/2025: Staff documented administration of polyethylene glycol daily except 12/17/2024 (refused) and 01/06/2025 (absent from home) (37 doses). On 01/07/2025 at 1:47 PM, Health and Wellness Director CC informed Surveyor s/he audited Resident 19's MAR dated 04/01/2024-11/30/2024 on 01/07/2025 and gave Surveyor a list of dates when staff documented they administered Resident 19's polyethylene glycol (summarized): April 2024- administered daily (30 doses). May 2024- administered daily except 05/23/2024 (MD appointment) (30 doses) June 2024- administered daily (30 doses) July 2024- administered daily except 07/18/2024 (MD appointment) and 07/23/2024 (refused) (29 doses) August 2024- administered daily except 08/10/2024 (refused) (30 doses) September 2024- administered daily except 09/14/2024 (refused) (29 doses) October 2024- Administered daily except 10/10/2024 and 10/18/2024 (appointments) and 10/22/24-10/24/2024 (held per MD) (26 doses) November 2024- administered daily except 11/21/2024 (refused) (29 doses) Individual Service Plan dated 07/23/2024: In the area of Medications: "Order and coordinate medications between family, health care providers and pharmacy ...will receive staff assistance with coordination and ordering of medications ...will receive physical assistance with taking medications ..." Example 2: Resident 21 Resident 21 was admitted to the facility on	N 352		

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12/04/2024 with diagnosis including hypertension and atrial fibrillation. Resident 21 was their own decision maker. Resident 21' ISP dated 12/16/2024 documented: Under the Medications Section- "Order and coordinate medications between family, healthcare providers and pharmacy. Provide assistance with administration of medications as needed. Take blood pressure daily. [Resident 21] is compliant and takes [his/her] meds whole with beverage of [his/her] choice. [S/he] is on Metoprolol and will have b/p monitored twice weekly and reported to d as necessary. [S/he] is on Eliquis, staff to observe for bleeding and bruising and to report to HWD/C. [Resident 21] takes Sertraline for Major Depression. [S/he] will be monitored for s/e and remain on the lowest possible dose for efficacy."

Resident 21's physician orders documented: Metoprolol 25 mg tab to be taken once daily in the morning for hypertension with a start date of 12/05/2024 and the following parameters noted Hold if systolic blood pressure less than 110 or heart rate less than 60.

Surveyor reviewed Resident 21's MAR for the months of December 2024 through January 7th, 2025, and observed the following 5 discrepancies between Resident 21's systolic blood pressure and heart rate values and staff's holding versus administration of his/her metoprolol:

-12/13/2024 (8:00 AM): Systolic blood pressure recorded as 105, staff documented administering metoprolol (despite being within parameters for holding).

-12/15/2024 (8:00 AM): Heart rate recorded as 40, staff documented administering metoprolol (despite being within parameters for holding).

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N 352	Continued From page 7 -12/16/2024 (8:00 AM): Heart rate recorded as 40, staff documented administering metoprolol (despite being within parameters for holding). -12/18/2024 (8:00 AM): Systolic blood pressure recorded as 90, staff documented administering metoprolol (despite being within parameters for holding). -12/15/2024 (8:00 AM): Heart rate recorded as 59, staff documented administering metoprolol (despite being within parameters for holding). Example 3: Resident 22 On 01/07/2025 at 8:37 AM, Surveyor interviewed Resident 22. Resident 22 reported s/he was legally blind and required eye drops daily. Resident 22 reported last month s/he missed all 3 of his/her eye drops because the provider forgot to reorder them on time. On 01/07/2025 at 12:20 PM, Surveyor interviewed Caregiver HH. Surveyor asked the provider's policy on reordering resident medications. Caregiver HH reported staff is supposed to notify nursing when medications are getting low so they can reorder through the pharmacy. Caregiver HH stated residents often will go a day or two without their medications because staff will not tell nursing until the medication is completely gone. Caregiver HH reported s/he worked on New Years day and 1 of Resident 22's eye drops was not available. On 01/07/2025 at 2:26 PM, Surveyor interviewed Health and Wellness Director CC. Health and Wellness Director CC reported s/he spoke to the on-call manager on 12/27/2024 and s/he	N 352		

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reordered the medications but did not think to document in Resident 22's record. Health and Wellness Director CC stated staff are supposed to inform nursing before residents run out of their medications.

Resident 22 was admitted to the provider on 12/15/2020 with diagnoses including legal blindness and macular degeneration. Resident 22 was their own legal decision maker. Resident 22's ISP dated 08/28/2024 documented: Under the Medications Section- "Order and coordinate medications between family, healthcare providers and pharmacy. Provide assistance with administration of medications as needed. [Resident 22] will received physical assistance with taking medications. [Resident 22] is completely blind but is able to make [his/her] needs known. [Resident 22] has multiple eye drops for glaucoma and cream for skin rashes. [Resident 22] was recently diagnoses with Hyphemia of [his/her] L eye (03/16/2023), this has resolved as of 05/2023. [S/he] continues with eye drops for glaucoma and ointment for dry eyes. If [s/he] were to have sudden severe pain, this should be reported immediately to the HWD/C and [his/her] family."

Resident 22's physician orders documented:
-Timolol Maleate Ophthalmic Solution with directions to instill 1 drop in left eye 2 times daily, with a start date of 03/16/2023.
-Erythromycin Ophthalmic Solution with directions to instill 1 application in left eye 2 times daily for dry painful eye, with a start date of 03/24/2023.
-Latanoprost Solution with directions to instill 1 drop in both eyes at bedtime related to macular degeneration, with a start date of 12/15/2020.

Surveyor reviewed Resident 22's December

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N 352	Continued From page 9 2024-January 7th 2025 MARs and observed 4 administrations with the above eye drops documented as "18" on 12/27/2024 and 01/01/2025. The charting codes for "18"=Other/See Med note. Surveyor reviewed Resident 22's charting notes and observed the following entries: - 12/27/2024 (at 21:39) Timolol Maleate Ophthalmic Solution, Erythromycin Ophthalmic Solution, Latanoprost Solution: "Med not on the cart." The record did not include any other evidence to show the provider followed up with the pharmacy or physician to see the status of Resident 22's above medications. On 01/07/2025 at 2:40 PM, Surveyors discussed concern of residents not received medications as ordered by providers with Executive Director A, Assistance Executive Director Q and Health and Wellness Director CC. Executive Director A stated a lot of times things were out of their control. Health and Wellness Director CC stated by the time the eye drops were reordered they had already run out, and staff should have notified nursing prior. Cross reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 352		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued,	N 406		

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the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.

This Rule is not met as evidenced by:
Based on record review, observation, and interview, the provider did not ensure 2 of 2 resident medications were disposed of after 30 days of the expiration date.

Findings include:

On 01/07/2025 at approximately 10:30 a.m., Surveyor observed the providers medication carts and observed the following expired medications:

-Resident 16 had a Ventolin HFA albuterol solution 108MCG/ACT to be taken as needed and an expiration date of 02/29/2024.

-Resident 20 had a Ventolin HFA albuterol solution 108MCG/ACT to be taken as needed

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N 406	Continued From page 11 and an expiration date of 09/30/2024 On 01/07/2025 at approximately 11:45 a.m., Surveyor reviewed the annual medication cart audit from the pharmacy, dated 05/21/2024. The pharmacy audit indicated that every cart had many expired medications. On 01/07/2025 at approximately 12:00 p.m., Surveyor interviewed Health and Wellness Director CC. Health and Wellness Director CC acknowledged the expired medications. Health and Wellness Director stated that the medications were PRN and had not been administered.	N 406		
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 staff accurately documented medication administration.	N 415		

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N 415	Continued From page 12 Staff continued to document administration of Resident 19's physician ordered polyethylene glycol after the medication had run out. This is a repeat violation. See Statement Of Deficiency (SOD) Z21G13 dated 11/13/2023. Findings include: On 01/07/2025 at 10:23 AM while inspecting medication cart #2 with Med Tech DD, Surveyor observed a half-full bottle of polyethylene glycol in the medication cart. The bottle's manufacturer's label identified it was a 14-dose bottle and the pharmacy label identified it was dispensed on 03/18/2024 for Resident 19. There were no additional bottles of polyethylene glycol for Resident 19 in the medication cart. On 01/07/2025 at 10:23 AM, Surveyor interviewed Med Tech DD. Med Tech DD examined Resident 19's bottle of polyethylene glycol dispensed 03/18/2024 and stated s/he agreed with Surveyor that the bottle was a little over half full. Med Tech DD stated s/he had not yet administered it to Resident 19 on 01/07/2025 because s/he took it after breakfast. Med Tech DD stated s/he would be administering it from the bottle dispensed 03/18/2024. Med Tech DD checked Resident 19's medication administration record (MAR) and verified 1 dose was to be administered daily. On 01/07/2025 at 11:50 AM, Surveyor interviewed Health and Wellness Director CC who stated s/he called pharmacy on 01/07/2025 and was informed Resident 19's polyethylene glycol was last dispensed in March 2024. On 01/07/2025, Surveyor reviewed Resident 19's	N 415		

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N 415	Continued From page 13 record. S/he was admitted 12/07/2022. Physician orders included polyethylene glycol 3350 Powder give 17 grams once daily for constipation. Mix with 8 ounces of preferred beverage. Start date 03/09/2024. Resident 19's MAR dated 04/01/2024- 01/07/2025 and Health Wellness Director CC's written audit (completed 01/07/2025) of Resident 19's MAR dated 04/01/2024- 11/30/2024 identified that from 04/01/2024 - 01/07/2025, staff documented administration of Resident 19's polyethylene glycol 269 times. On 01/07/2025 at 2:40 PM, Surveyors discussed concern of staff documenting administration of medication when it was not administered with Executive Director A, Assistance Executive Director Q and Health and Wellness Director CC. Health and Wellness Director CC stated staff should not document administration of medications if not administered. Cross Reference: N0352 DHS 83.32 (3)(h) Rights Of Residents: Receive Medication	N 415		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that semi-annual evacuation drills for 2023 and 2024 were completed.	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013589	A. BUILDING: _____ B. WING _____	R-C 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BROOKFIELD AL	660 WOELFEL ROAD 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 526	Continued From page 14 Findings include: On 01/07/2025 at approximately 2:00 p.m., Surveyors reviewed the facility's environmental records for semi-annual evacuation drills. Surveyors found one documented evacuation drill for 2024, dated 07/31/2024 and no evacuation drills for 2023. Surveyors asked Executive Director A if there was any evidence of documented semi-annual evacuation drills for 2023 and 2024. Executive Director A stated that the facility maintenance person was new to the position and was still working on getting the drills in order. Executive Director A acknowledged there were several elopement risk drills with no information about what happened during the drill. Executive Director A was given until 01/08/2025 at 10:00 a.m. to provide follow up documentation. On 01/07/2025 at 4:01 p.m., Surveyors received an email from Executive Director A with environmental records that included fire drill reports but no evacuation drill reports. Executive Director A was given until 01/10/2025 at 12:00 p.m. to provide additional evacuation drill reports. Surveyors did not receive any additional documentation of evacuation drills.	N 526		