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 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BROOKFIELD AL	660 WOELFEL ROAD BROOKFIELD, WI 53045

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{N 000}	Initial Comments On 06/13/2025, Surveyor conducted 1 verification visit and 1 complaint investigation. One deficiency was identified and was a repeat violation. See Statement Of Deficiency (SOD) Z21G12 dated 06/21/2023 and Z21G16 dated 01/07/2025. Four of 5 deficiencies from SOD Z21G16, dated 01/07/2025, were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 70	{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, 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. 05/21/2025 AM, staff administered Resident 25's medications to Resident 23 and Resident 23's medications to Resident 24. Resident 23 was	{N 352}		

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

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{N 352}	Continued From page 1 hospitalized on 05/21/2025 and passed away 05/24/2025. On 06/13/2025, Resident 4's bottle of physician ordered scheduled latanoprost eye drops contained drops 43 days after pharmacy dispensed 30 days' worth, bottle of physician ordered scheduled prednisolone eye drops contained drops 42 days after pharmacy dispensed 25 days' worth, and bottle of physician ordered scheduled dorzolamide eye drops contained drops 42 days after pharmacy dispensed 30 days' worth. This is a repeat deficiency. See Statement of Deficiency (SOD) Z21G12 dated 06/21/2023 and Z21G16, dated 01/07/2025. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 95 residents within the client groups of physically disabled, advanced aged, irreversible dementia/Alzheimer's. On 05/22/2025, the Department received a complaint regarding a medication error. Example 1- Resident 23 and Resident 24 On 05/22/2025, the Department received a facility self-report dated 05/22/2025 (summarized): On 05/21/2025 Resident 23 received medications intended for another resident. Vitals were monitored and Resident 23 was sent to the emergency room for evaluation and admitted to the ICU. Resident 24 was monitored at the facility with no adverse reactions.	{N 352}		

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{N 352}	Continued From page 2 On 06/02/2025 at 10:32 AM, Surveyor received Resident 23's hospital record dated 05/21/2025-05/24/2025 via fax from hospital. Discharge Summary- " ...admitted to the hospital on May 21st due to hypotension and bradycardia. Patient was reportedly given incorrect medications ... [s/he] was hypotensive and bradycardic and admitted to ICU. [S/he] was started on dopamine with improvement in blood pressure and heart rate ...[S/he] remained lethargic and respiratory status worsened. Goals of care were discussed with family and decision was made for transition to hospice care. [S/he] will be admitted to inpatient hospice ..." On 06/13/2025, Surveyor reviewed the facility's Incident Investigation dated 05/21/2025 (summarized): On 05/21/2025, Caregiver JJ gave medications meant for Resident 25 to Resident 23, and medications meant for Resident 23 to Resident 24. Caregiver JJ stated during the investigation interview that s/he had come in to help pass medications for a few hours and because the unit was unfamiliar to him/her s/he felt stressed and anxious. Caregiver JJ stated Resident 23 was still in bed and would not acknowledge him/her, so s/he labeled the medication cup s/he had put Resident 23's medication in with Resident 23's room number and put the cup in the medication cart. After providing resident cares and finishing medication pass (except for Resident 23 and Resident 25), Caregiver JJ was in the dining room during breakfast holding 2 medication cups each labeled with Resident 23's and Resident 25's room numbers. Caregiver JJ asked Caregiver KK which resident was room (Resident 25's room number) but may have gotten confused and actually asked which resident was (Resident 23's room number). Caregiver KK pointed to Resident	{N 352}		

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{N 352}	Continued From page 3 23 and Caregiver JJ gave Resident 23 Resident 25's medications. Caregiver JJ stated s/he then assumed the other resident at the table was Resident 25, however it was Resident 24, so Caregiver JJ gave Resident 24 Resident 23's medication. When Caregiver KK approached Resident 24 to administer his/her medications, Resident 24 stated s/he had already received them. Caregiver KK informed Health and Wellness Director CC. Summary of Findings: " ...[Caregiver JJ] did not follow the 5 rights repeatedly during the 9 am med pass specifically as it relates to "Right Resident'. There were multiple occasions where [s/he] could have accurately verified the resident in question had [s/he] wished to. [Caregiver JJ also had meds for more than one resident in [his/her] hands when approaching [Resident 23] thereby increasingly [sic] the likihoood [sic] [s/he] could give the wrong medication. This practice if highly frowned upon as its [sic] known to be the source of med errors." Post Investigation Actions: "[Caregiver KK] terminated on 5.22.25 and med training will be conducted across the board." Incident Report dated 05/27/2025 " ...Resident 23 ...Date of Incident: 05/21/2025 ...Nature of Incident Medication, Staff Administered, Wrong Drug, not properly identified ...Type of Injury/Impairment: Death ...Initial Actions Taken Blood Pressure 080/40 [sic], Called 911 ... [Resident 23] was given medication intended for another resident. [S/he] was monitored and sent out approx. [sic] an hour after administration as [his/her] [blood pressure] and heart rate were low. [S/he] was admitted to ICU in unstable condition. To [sic] transitioned to hospice care within approx. [sic] 24 hours or so and expired thereafter ..."	{N 352}		

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{N 352}	Continued From page 4 On 06/13/2025, Surveyor reviewed Resident 23's record. S/he was admitted 05/05/2025. Physician orders included: amlodipine besylate 5 MG 1 tablet once daily related to hypertensive heart disease; levothyroxine sodium 75 MCG 1 tablet once daily related to hypothyroidism; PreserVision AREDS 2+ multi vitamin 1 capsule daily for supplement; sodium bicarbonate 650 MG twice daily for supplement; and hydralazine HCl 50 MG 1 tablet 3 times daily related to hypertensive heart disease without heart failure. Observation Note dated 05/21/2025: "This morning, [Resident 23] received amlodipine besylate 10mg, carvedilol 6.25mg, hydralazine 100 mg, hydrochlorothiazide 25 mg, losartan potassium 100mg, potassium chloride 40 meq [sic], multivitamin, venlafaxine ER 225mg, and vitamin d3 [sic]. [Primary Care Physician] and [family member] were notified. Vitals were monitored and [Resident 23] was sent to ED for evaluation." MAR: On 05/21/2025, Caregiver JJ documented administration of Resident 23's physician ordered: amlodipine besylate 5 MG, levothyroxine sodium 75 MCG, PreserVision AREDS 2+ multi vitamin, sodium bicarbonate 650 MG, and hydralazine HCl 50 MG. Individual Service Plan (ISP) dated 05/05/2025: In the area of Medications- " ...[Resident 23] will receive medications as prescribed ..." On 06/13/2025, Surveyor reviewed Resident 24's record. S/he was admitted 04/09/2025. Physician orders included: folic acid 1 MG 1 tablet once daily for supplement; losartan potassium 50 MG 1 tablet once daily for high blood pressure; Prilosec OTC 20 MG 1 tablet once daily for	{N 352}		

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{N 352}	Continued From page 5	{N 352}		

gastroesophageal reflux disease; vitamin D3 50 MCG 1 tablet once daily; ammonium lactate external cream 12% apply to bilateral feet topically twice daily for dry skin; and metoprolol tartrate 25 MG 1 tablet twice daily for high blood pressure.

Observation note dated 05/21/2025: "This morning, [Resident 24] received amlodipine 5mg, hydralazine 50mg, levothyroxine 75mcg, preservision areds [sic], and sodium bicarbonate 650mg. ...Vitals will be monitored throughout the day and scheduled AM meds will be held."

MAR: On 05/21/2025, staff documented "18" (other/see med note) for Resident 24's 8:00 AM medications (folic acid 1 MG, losartan potassium 50 MG, Prilosec OTC 20 MG, vitamin D3 50 MCG, ammonium lactate external cream 12%, and metoprolol tartrate 25 MG).

ISP dated 04/23/2025-
In the area of Medications: "...[Resident 24] will receive medications as prescribed ..."

On 06/13/2025 at 10:15 AM, Surveyor interviewed Assistant Executive Director (AED) Q who stated on 05/21/2025 Caregiver JJ administered Resident 25's medications to Resident 23, Resident 23's medications to Resident 24 and Resident 25's medications were not administered. AED Q stated the error was due to Caregiver JJ not correctly identifying the residents at time of administration.

On 06/13/2025, Surveyor reviewed facility policy titled Medications & Treatments- Medication Error dated 03/2003 " ...Associates providing, assisting, or administering medication to residents are expected to follow the 7 rights of medication

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{N 352}	Continued From page 6 administration that include-right medication, right person, right dose, right time, right route, right to refuse and right documentation ..." Example 2- Resident 4 On 06/13/2025 at 10:31 AM while inspecting the medication cart #3 with Health and Wellness Coordinator (HWC) H, Surveyor observed Resident 4's eye drops in the medication cart: A clear plastic bag with pharmacy label attached containing 1 bottle latanoprost eyedrops Pharmacy label identified: Latanoprost 0.0005% [ophthalmic] solution, instill 1 drop into left eye once daily at bedtime Dispensed 04/30/2025 "Opened 4/30/25" was handwritten on pharmacy label (Photo 1). HWC H stated maybe 2-3 drops remained in bottle and there were no other bottles of Resident 4's Latanoprost 0.0005% eye drops were in the medication cart. A plastic bag with pharmacy label attached containing 1 bottle prednisolone ACE 1 % eyedrops Pharmacy label identified: Prednisolone ACE 1 % eyedrops, instill 1 drop in left eye 4 times daily Dispensed 05/02/2025 "opened on 5/2/25" was handwritten on pharmacy label (Photo 2). HWC H stated the bottle was approximately 1/8 full and no other bottles of Resident 4's prednisolone ACE 1 % eyedrops were in the medication cart.	{N 352}		

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{N 352}	Continued From page 7 A plastic bag with pharmacy label attached containing 1 bottle dorzolamide 2 % eye drops Pharmacy label identified: Dorzolamide 2% [ophthalmic] solution, instill 1 drop into left eye 3 times daily Dispensed 05/02/2025 "opened 5/9/25" was handwritten on the pharmacy label (Photo 3). HWC H stated the bottle was approximately ¾ full and no other bottles of dorzolamide 2% eye drops were in the medication cart. On 06/13/2025 at 12:56 PM, Surveyor interviewed Pharmacy Tech II who stated a Resident 4's: Latanoprost 0.0005% [ophthalmic] solution eyedrops were last dispensed 04/30/2025, quantity 30 days' worth; prednisolone ACE 1 % eye drops were last dispensed 05/02/2025, 25 days' worth; and dorzolamide 2% eye drops were last dispensed 05/02/2025, 30 days' worth. Pharmacy Tech II stated Resident 4's eye drops were not auto-filled so facility needed to notify pharmacy for refills. On 06/10/2025, Surveyor reviewed Resident 4's record. S/he was admitted 08/04/2022. Diagnoses included primary open-angle glaucoma, right eye and unqualified visual loss both eyes. Physician orders included: latanoprost 0.0005% [ophthalmic] solution, instill 1 drop into left eye once daily at bedtime; prednisolone ACE 1 % eyedrops, instill 1 drop in left eye 4 times daily; and dorzolamide 2% [ophthalmic] solution, instill 1 drop into left eye 3 times daily. Medication Administration Record (MAR): From 04/30/2025-06/12/2025, staff documented administration of Resident 4's: latanoprost 0.0005% eyedrops 43 days; from 05/02/2025-	{N 352}		

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{N 352}	Continued From page 8 06/12/2025 prednisolone ACE 1 % eyedrops and dorzolamide 2% eyedrops 42 days each. Individual Service Plan (ISP) dated 10/18/2024: In the area of Medications: " ...Resident 4 is blind ...has multiple eye drops for glaucoma and [his/her] blindness ...Staff to physically assist [Resident 4] with taking [his/her] medications ..." On 06/13/2025 at approximately 2:00 PM, Surveyor discussed concern regarding medication errors with AED Q, HWC H, Director of Clinical Services LL, and Interim Executive Director MM. AED Q stated the nurse practitioner (NP) from contracted physician's service was in the building at the time the medication error involving Resident 23 and Resident 24 was discovered on 05/21/2025. AED Q stated the NP saw the residents immediately and directed staff to monitor them closely and take vitals hourly. AED Q stated Resident 23 was sent to hospital within an hour of NP seeing him/her because his/her blood pressure had dropped. AED Q stated all medication passers were retrained in medication administration and monitored administering medications following the 05/21/2025 incident. HWC H stated staff possibly did not administer full drops of Resident 4's eye drops and they would check into it.	{N 352}		