

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Aria of Brookfield		STREET ADDRESS, CITY, STATE, ZIP CODE 18740 W Bluemound Rd Brookfield, WI 53045	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713</p> <p>Based on interview and record review, the facility did not immediately consult with the resident's physician when there is a need to alter treatment for 1 out of 3 Residents (R) reviewed for physician notification (R5).</p> <p>R5 had a change of condition and the facility failed to consult the physician regarding the change of condition. R5 had weights that increased or decreased out of parameters and the physician was not updated.</p> <p>This is evidenced by:</p> <p>Facility policy, titled, Change in Condition Process, last reviewed 3/01/21, states in part . Policy Statement: The purpose of this policy is to promptly implement a system for a resident having a change in condition. A change in condition is defined as an improvement or decline in their physical, or psychosocial status. Procedure: Change of Condition: 1. When a change of condition or change in baseline is observed and reported, the licensed nurse is responsible for evaluating the Resident's condition. Examples of a condition change are as follows, but not limited to; a. Weight loss, pain or change in appetite, change in ability to chew. 3. The physician will be notified.</p> <p>Facility policy titled, Weight Management, last reviewed, 3/01/21, states in part . Policy Statement: The facility's policy is to provide care and services to weight management by State and Federal regulations. Procedure: 2. All residents will be weighed every month unless otherwise ordered by the physician or deemed necessary by the dietician or the interdisciplinary team. 4. The Dietician should evaluate weights, notify appropriate disciplines of significant changes, and initiate corrective measures. 5. A re-weight will be obtained for any weight change identified as a significant change from previous weight unless the physician has ordered other parameters. 7. If possible, the weights should be obtained at the same time of day, preferably in the morning and with the same scale to ensure consistency. 10. The resident's nurse will notify the physician and the resident or resident representative of any significant unexpected or unplanned weight changes.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interact Version 4.5 Tool for Change in Condition: When to report to the MD/NP/PA, states in part . Immediate Notification: Any symptom, sign or apparent discomfort that is: Acute or Sudden in onset, and: A Marked Change (i.e., more severe) in relation to usual symptoms and signs, or Unrelieved by measures already prescribed. Weight Loss: Report Immediately: 5% (percent) or more within 30 days. Weight Gain: > (greater than) 5 lbs (pounds) in one week in resident with CHF (congestive heart failure), chronic renal failure, other volume overload state.</p> <p>R5 was admitted to the facility on [DATE], with diagnoses, including, but not limited to, hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease, acute respiratory failure with hypoxia, type 2 diabetes mellitus, COPD (chronic obstructive pulmonary disease), acute pulmonary edema, emphysema, CHF (congestive heart failure).</p> <p>R5's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 6/05/24 indicates R5 is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15.</p> <p>R5's physician orders, states in part .</p> <p>Enter post-dialysis weight/dry weight that was obtained after dialysis treatment was concluded (documented in dialysis binder). Notify MD (medical doctor) if weight is more than 5 lbs different from previous post dialysis weight/dry weight. One time a day every Mon (Monday), Wed (Wednesday), Fri (Friday). Start date: 4/26/24.</p> <p>Weight +/- (gain/loss) 3 lbs per day or +/- 5 lbs per week, update MD.</p> <p>Progress Note from 8/26/24, at 9:54 AM, follow up cardio (cardiology) visit states in part . 5. Weigh daily and notify AH provider of weight gain >3lbs overnight or 5lbs in 1 week.</p> <p>R5's weights are documented from 8/02/24 until present as follows:</p> <p>8/02/24 - 132.7 lbs</p> <p>8/05/24 - 138.8 lbs (up 6.1 lbs)</p> <p>8/09/24 - 131.3 lbs (down 7.5 lbs)</p> <p>8/14/24 - 128.1 lbs</p> <p>8/16/24 - 128 lbs</p> <p>8/19/24 - 129 lbs</p> <p>8/21/24 - 124.3 lbs</p> <p>8/26/24 - 121.8 lbs</p> <p>8/28/24 - 120.8 lbs</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8/30/24 - 119 lbs</p> <p>9/02/24 - 118 lbs</p> <p>9/04/24 - 140 lbs (up 22 lbs)</p> <p>9/06/24 - 139.3 lbs</p> <p>9/09/24 - 140 lbs</p> <p>Note: R5 had significant weight changes on 8/05/24, 8/09/24 and 9/04/24 and the physician was not consulted with related to these changes.</p> <p>Note: R5's orders also have order to update the physician with on increase of +/- 3 lbs in a day or +/- 5 lbs in a week. Weights were not completed daily to check for a weight gain or loss but completed only on dialysis days.</p> <p>On 9/09/24, at 4:20 PM, Surveyor interviewed RD C (registered dietician). Surveyor asked RD C the facility process for getting weight and reviewing them. RD C states, weights are obtained on admission unless a resident has something going on. Weights are then weekly for 4 weeks, then monthly. Dialysis residents get pre and post dialysis weights are those are recorded. There is a dialysis dietician who works in the dialysis center. We are considering not just weight but meal intakes, dialysis, etc. Surveyor asked RD C what she does with the weight when she reviews them. RD C stated, I talk with the dialysis dietician about a residents weight change and continue to monitor their weight on their next dialysis treatment. I would also talk with the resident if they were able. Surveyor asked RD C if she would update the physician if a residents weight was off from the parameters given. RD C stated, Nursing would do the updating of the physician according to their policy.</p> <p>On 9/09/24, at 5:00 PM, Surveyor interviewed RN D (registered nurse). Surveyor asked RN D about the facility process for monitoring weights. RN D stated, we do pre and post dialysis weight on dialysis days. The folder gets brought back to the nurse who would then review and update if needed. Surveyor asked RN D who monitors resident weights. RN D stated, the nephrologist in dialysis would be monitoring their weights. Surveyor asked RN D about R5's weight orders. RN D stated, we do weights on dialysis days and would do something different if it was ordered. Surveyor reviewed R5's orders with RN D who indicates staff should be completing daily weights for R5 if that was what was ordered.</p> <p>On 9/09/24, at 6:05 PM, Surveyor interviewed LPN E (licensed practical nurse). Surveyor asked LPN E the facility process for obtaining resident weights. LPN E stated, the CNA (certified nursing assistant) gets the weight then they report it to me. If there is a change, I would update the physician. Surveyor asked LPN E process for residents on dialysis and residents with CHF. LPN E stated Dialysis residents are before and after dialysis. Residents with CHF weights would be done according to the physicians orders. I believe weekly or every 3 days. Surveyor asked LPN E what the facility follows for a standard of practice. LPN E stated, AMDA. (Society for Post-Acute and Long-Term Care Medicine). Surveyor asked LPN E if she has an order for +/- 3lbs in a day or +/- 5lbs in a week how often weights should be obtained. LPN E stated, then weights should be done daily.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/09/24, at 6:05 PM, Surveyor interviewed CNA F (certified nursing assistant). Surveyor asked CNA F process for obtaining resident weights. CNA F stated weights are obtained then given to the nurse or charted. If weight is up or down, we let the nurse know or try to obtain a re-weight. Weights are usually monthly unless there are orders for something else.</p> <p>On 9/09/24, at 6:15 PM, Surveyor interviewed LPN G. Surveyor asked LPN G about the process for weights. LPN G stated weights are obtained on residents shower days. A CNA obtains the weight and reports it to the nurse. Would need to notify the physician if weight is up or down. Then would assess the resident for other symptoms (i.e., edema). Surveyor asked LPN G what the facility follows for a standard of practice. LPN G stated, AMDA or Interact. Surveyor asked LPN G if she has an order for +/- 3lbs in a day or +/- 5lbs in a week how often weights should be obtained. LPN G stated daily.</p> <p>The facility failed to update R5's physician of weights that were outside of the given parameters. The facility also failed to obtain daily weights for R5 as ordered.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29360</p> <p>Based on observation, interview and record review the facility did not ensure each resident (R) receives adequate supervision and assistance to prevent accidents for 3 of 4 residents reviewed (R4, R3 and R12).</p> <p>R4 has a history of being verbally aggressive towards others. R4 was verbally aggressive towards R12 and verbally aggressive and physically hit R3. R4 was not supervised when he was out of his room and interacting with other residents.</p> <p>Evidenced by:</p> <p>R4 was admitted to the facility on [DATE]. R4's diagnoses include metabolic encephalopathy, dementia and diabetes.</p> <p>R4's most recent MDS (Minimum Data Base), with an ARD (Assessment Reference Date) of 6/19/24, indicates R4 has moderate cognitive impairment and can independently wheel his wheelchair.</p> <p>R4's care plan focus areas include, in part, the following:</p> <p>*The resident is/has potential to be verbally aggressive r/t (related to) dementia w/ (with) delusions and hallucinations, ineffective coping skills, mental/emotional illness, poor impulse control. Resident can be tearful at times, yell and scream at staff and peers, has tangential thoughts and statements. Resident makes false accusations (food). Revision on 5/23/24. Interventions include, in part, the following: Monitor behaviors daily. Document observed behavior and attempted interventions. Revision on: 5/23/24.</p> <p>*The resident has limited physical mobility. Revision on 1/3/24. Interventions include, in part, the following: Locomotion: The resident is able to self-propel in his wheelchair, revision on 7/17/24.</p> <p>R4's Progress Notes include, in part, the following:</p> <p>8/7/24, 19:00 (7:00 PM): Type: Behavior Note. Describe behavior, notifications: Writer overheard resident (R4) yelling profanities and scream get the hell away from me, another male resident (R3) yelled get off me. As writer came out a (sic) room Resident (R4) than (sic) punched the other resident (R3) in the eye, and another punch to the forehead. Resident (R3) grabbed his (R4) shirt and hand (the one he was being punched with) and the aide ran up and separated the two. Resident (R4) hands were examined, and there was redness but no swelling or bruising. Staff will continue to monitor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8/8/24, 14:43 (2:23 PM): Type: Interdisciplinary Team Note. Late entry. Note Text: IDT (Interdisciplinary Team) meeting s/p (status post) resident physical altercation with another resident. Root cause analysis, resident continues to have active verbal behaviors with staff. Resident often refuses medications r/t to (sic) his diagnoses and treatments. Resident who received physical aggression was unaware and can not comprehend other residents behaviors. Resident who initiated aggression was aware of behavior at the time of incident. Nursing intervention - Residents were separated at time of incident. Care plan reviewed.</p> <p>8/27/24, 11:08 (AM). Type: Health Status Note. Note Text: Resident verbally aggressive today, refusing meds (medications), yelling at writer multiple times, writer did re-direct and resident went to room, resident seemingly very confused today.</p> <p>9/9/24, 12:22 (PM). Type: Behavior Note. Describe behavior, notifications: Writer was informed that resident was witnessed to have a verbal altercation with another resident where resident was the verbal aggressor. Witness was able to de-escalate the situation and redirect each resident with no resistance from either party. Resident is currently in his room with call light and side table within reach. All needs are met at this time. Staff will continue with current care plan.</p> <p>On 9/9/24, at 12:10 PM Surveyor observed R4 in the dining room. There were staff in the dining room passing out the noon meal. R4 was self-propelling in the dining room. R12 walked towards R4, talking nonsensical. R4 began to yell at R12 to go away and shut up. R12 continued to talk nonsensical and R4 continued to yell at R12 to shut up and go away. Dir Act I (Director of Activities) intervened, leading R12 to a table for her meal and R4 was allowed to leave the dining room on his own.</p> <p>On 9/9/24, at 1:44 PM Surveyor observed R4 self-propelling in the hallway. There was no staff in view.</p> <p>On 9/9/24, at 1:45 PM Surveyor interviewed RN H. RN H is the Unit Manager and was passing medications. Surveyor asked RN H when R4's behaviors are monitored. RN H stated staff monitor R4's behaviors when he is agitated. RN H stated staff could hear when R4 becomes agitated because he yells and is very loud. Surveyor asked RN H if she was aware of the interaction that occurred at 12:10 PM between R4 and R12. RN H stated she was not aware of the interaction between R4 and R12. RN H stated staff should have informed her of the interaction.</p> <p>On 9/9/24, at 1:50 PM Surveyor interviewed Dir Act I. Surveyor asked Dir Act I about R4's behaviors. Dir Act I stated R4 has a temper, throws trays into the hallway at mealtimes, R4 will yell at other residents at times but mostly at staff. Surveyor asked Dir Act I if she informed RN H, who was R4's nurse, of the altercation that occurred in the dining room between R4 and R12. Dir Act I stated she did not report the interaction to anyone. Dir Act I stated that she did not report the interaction because there was no physical interaction only verbal interaction and that happens a lot.</p> <p>On 9/9/24, at 4:30 PM, Surveyor interviewed LPN J (Licensed Practical Nurse). Surveyor asked LPN J about R4's behaviors. LPN J stated R4 can get loud and yell at other residents, staff will separate the residents. LPN J stated that staff try to explain to R4 that the other resident does not understand. Surveyor asked LPN J how often R4 has behaviors. LPN J stated every couple of days or so R4 yells at other residents. Surveyor asked LPN J would she expect staff to report any verbal or physical interactions between R4 and other residents. LPN J stated she would expect staff to report any verbal or physical interactions and she would document the behaviors in R4's medical record.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24, at 4:25 PM, Surveyor interviewed MT K (Medication Technician). Surveyor asked MT K about R4's behaviors. MT K stated R4 is loud and has yelled at R12 in the past.</p> <p>On 9/9/24, at 4:30 PM, Surveyor interviewed LPN L (Licensed Practical Nurse). Surveyor asked LPN L about R4's behaviors. LPN L stated she observed the interaction between R4 and R3. LPN L stated she heard R4 yelling, came out of a room and observed R4 hit R3 twice. Another staff was attempting to separate R4 and R3. LPN L stated R4 yells at R12 all the time. Staff attempt to redirect and separate R4 and any other resident he is having a negative interaction with, either verbal or physical. LPN L stated the only time she documents R4's behaviors is when R4 yells at other residents and staff are unable to calm down or redirect R4. LPN L stated R4 is always sad and cries daily about his family and being at the facility.</p> <p>On 9/9/24 Surveyor interviewed DON B (Director of Nursing) and RN D (Registered Nurse). Surveyor asked DON B when she would expect staff to monitor and document R4's behaviors. DON B stated she expects staff to monitor R4's behaviors every shift. DON B stated she expects staff to report all of R4's behaviors to R4's nurse and all of R4's behaviors would be documented in his medical record.</p> <p>RN D stated R4 is very emotional, and staff can get immune to R4's behaviors. RN D stated it is her expectation that staff would monitor and document all of R4's behaviors.</p> <p>On 9/9/24, at 6:08 PM, NHA A informed Surveyor that R4 was to be one on one to monitor R4's behaviors.</p> <p>On 9/9/24, at 6:15 PM, Surveyor interviewed DSS M (Director of Social Services). Surveyor asked DSS M to describe R4's behaviors. DSS M stated R4 is very confused, he does not want to be at the facility, staff attempt to redirect R4 when he yells at his family and staff. DSS M stated R4 and R12 have verbal altercations weekly. DSS M stated nursing staff will separate and redirect R4 and R12. DSS M stated staff should document all of R4's behaviors.</p>		