

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 12/11/2024
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>50700</p> <p>Based on observations, and interviews, the facility did not ensure residents had a safe, clean, comfortable and homelike environment for residents that utilize the 2 south hallway or dining area, the 2 [NAME] dining area and residents that utilize the first-floor dining area. This had a potential to effect 95 residents residing in the facility.</p> <p>Example 1:</p> <p>*Orange and brown stains observed to tables and floors in the first-floor dining area, dried food stuck to table tops and residents currently sitting in locations, waiting to eat breakfast, dried dinner meal ticket stuck to the tabletop.</p> <p>*2 South dining area observed with crumbs on the floor by the couch and television and the vinyl couch and chairs in dining area has layers of dried white and yellow and green debris stuck to furniture, residents currently eating breakfast in area that was being observed.</p> <p>*2 [NAME] dining room prior to breakfast, dining area had green dried debris and white hard rice shaped debris with brown dried liquid on the table tops and on the floor.</p> <p>Example 2:</p> <p>*Brown water stains were observed on multiple ceiling tiles in the hallway outside the 2 South dining room and on a ceiling tile near the entrance to the 2 East/West unit from the 2 South unit.</p> <p>* There are multiple scattered pieces of cereal on the piano as well as the piano bench located in the 2 South dining room.</p> <p>*On the wall located between Resident (R)20 & R21's rooms there are four metal pieces on the wall which appeared to have hung a picture from. The bottom two pieces are approximately six inches above the handrail and are approximately 1/4 inch in size.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525424
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>* A dining room chair in the 2 South dining room had dried white material along the front edge and multiple areas of dried food throughout the chair cushion. An over bed table in the 2 South dining room has dried material throughout the top of the over bed table. The white top of the blue & white cooler on the floor in the 2 South dining room has dried on orange and brown liquid. A Styrofoam and plastic cups are floating in the water inside the cooler.</p> <p>Findings include:</p> <p>The facility policy titled Housekeeping Procedure dated 1/1/21, documents: Procedure: Daily Cleaning: 1. Housekeeping/Environmental Services to adhere to Daily Cleaning Procedures. 2.Common areas to include, public restrooms, hallways etc., shower rooms.</p> <ul style="list-style-type: none"> - Tables, counters, window ledges, handrails and any high touch surface will be cleaned and disinfected daily. - Floors will be swept and mopped at minimum 1 time per day and more as needed. - Toilets, counters, mirrors and high touch areas will be cleaned and disinfected. <p>On 12/10/2024, at 8:14 AM, Surveyor observed the 1st floor dining area. Surveyor observed orange and brown stains on the floor and debris of yellow and white substances on the floor as well as open butter wrappers and sugar wrappers. The tables in this dining area had yellow and white chunks and dark brown debris with white granules on the tabletops. Surveyor observed another tabletop with a meal ticket from dinner dried and stuck to the tabletop.</p> <p>On 12/10/2024, at 8:42 AM, Surveyor interviewed Housekeeping-Q who stated the condition of the 1st floor dining area is from dinner last night. Housekeeping-Q states leaves at 3:00 PM and can't clean dining areas after dinner because housekeeping staff is no longer at the facility. Housekeeping-Q states that that housekeeping staff did not arrive to the facility until after 8:00 AM, which had residents already eating in the above dining areas. Housekeeping-Q states tables in the dining area on the 1st floor are dirty and that Housekeeping-Q will be cleaning these areas as soon as possible.</p> <p>On 12/10/2024, at 8:57 AM, Surveyor observed the 2 south dining area and observed food substances that had dripped down the window and dried onto the window. Food debris was observed on the tables, chairs, couch and the floor, and there was a half-eaten piece of toast and scrambled eggs on the floor under a table.</p> <p>On 12/10/2024, at 8:57 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-T who stated the substance on the window looked like dried food. CNA-T stated that housekeeping is the department that cleans the dining area, and that CNA-T would let them know that the window had to be cleaned.</p> <p>On 12/10/2024, at 10:34 AM, Surveyor interviewed Housekeeping-R who stated that housekeeping comes in at 8:00 AM and that dining areas should be cleaned first.</p> <p>On 12/10/2024, at 10:58 AM, Surveyor observed the 2 west dining area. Surveyor observed that that there were dried green chunks of debris and white, rice shaped, hard debris with dried brown liquid on the tabletops and the floor. There was a gripper sock on the floor and empty sugar packets, a straw, and heel protectors on a table.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/10/2024, at 11:54 AM, Surveyor observed the 2 south dining area and observed crumbs and debris on the floor and chairs, as well as the couch. A half-eaten piece of toast and scrambled eggs were observed on floor.</p> <p>On 12/10/2024, at 11:58 AM, Surveyor observed the 2 west dining area and noted that there were chunks of debris still present on tabletops. Surveyor observed housekeeping sweeping and moping the floor. Surveyor observed the floors being cleaned but the food debris was still present to tabletops from the day prior.</p> <p>On 12/10/2024, at 12:37 PM, Surveyor observed the 2 south dining area and residents were observed eating their lunch. Surveyor noted that there were still crumbs and debris on the floor and chairs and couch. Surveyor noted that a half-eaten piece of toast and scrambled eggs remained on the floor under the table.</p> <p>On 12/10/2024, at 12:39 PM, Surveyor observed 2 west dining area and observed residents sitting at the table and eating lunch. Surveyor observed that the residents were eating lunch next to a resident's lunch plate with the tabletop still having dried green chunks and white rice shaped debris and brown dried liquid. Surveyor observed the residents eating at this table despite the tabletop remaining dirty.</p> <p>Surveyor made multiple observations during the lunch service in all 3 dining areas and noted that the resident meals were served in dining areas that were not cleaned from previous meals.</p> <p>On 12/10/2024, at 2:06 PM, Surveyor observed the 2 south dining area and observed dried layers of debris still present on chairs and the couch.</p> <p>On 12/10/2024, at 2:09 PM, Surveyor observed the 2 west dining area and observed dried green chunks of debris to the top of the table and white rice shaped hard debris on tabletop with dried brown liquid.</p> <p>On 12/11/2024, at 7:42 AM, Surveyor interviewed Dietary Aide-S, who stated the dietary department is not responsible to clean dining area. Dietary aide-S stated that dietary staff only cleans the kitchenette area and if the dining area gets dirty that housekeeping staff is responsible for cleaning it.</p> <p>On 12/11/2024, at 7:44 AM, Surveyor observed the 2 west dining area and there were dried green chunks of debris to the top of the table and white rice shaped hard debris on the tabletop with dried brown liquid. Two dinner trays were observed to still be on a table in the dining room and there were 5 residents in dining area awaiting breakfast despite food trays from previous meals remaining and not being cleaned or picked up</p> <p>On 12/11/2024, at 7:44 AM, Surveyor observed dining area on first floor and observed dried debris on tables and floor in dining area.</p> <p>On 12/11/2024, at 7:49 AM, Surveyor observed the 2 south dining area and observed crumbs on the floor and tabletops, dried spilled liquid on the floor and tables. Surveyor observed that the chairs and the couch that is made from vinyl had layers of debris still on furniture from the previous day.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/11/2024, at 7:55 AM, Surveyor interviewed R19 who stated the dining area could be cleaner if the facility would focus more on cleaning the area.</p> <p>On 12/11/2024, at 8:10 AM, Surveyor interviewed CNA-U who revealed that housekeeping cleans all 3 dining areas and that about 8 residents will come to this dining area for meals. CNA- U stated that there are only 5 residents for breakfast today because a few residents wanted to sleep. Surveyor observed residents being served breakfast in the dining room and Surveyor pointed out the dried food debris from the previous day to CNA-U. CNA-U stated that housekeeping usually cleans this area, and Surveyor observed CNA-U cleaning the tabletop.</p> <p>On 12/11/2024, at 08:25 AM, Surveyor interviewed Housekeeping Director-P who stated that housekeeping responsibilities are to clean the dining area daily and in between meals. Director-P explained that the responsibilities of housekeeping staff are to clean tabletops, the chairs and couch as well as anything in that dining area. Surveyor and Housekeeping Director-P went to the above dining areas and Housekeeping Director-P stated that the layers of debris on the furniture and dinner debris were present from the previous day. Housekeeping Director-P stated that education would be provided to staff as there shouldn't be dried food in dining areas.</p> <p>On 12/11/2024, at 08:47 AM, Surveyor interviewed Housekeeping Director-P who stated that audits are completed 2 to 3 times a week in the building to make sure staff is completing tasks. Housekeeping Director-P stated that he is going to go to the above areas and start education with staff and begin cleaning the affected areas.</p> <p>On 12/11/2024, at 09:50 AM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the above concerns to all 3 dining areas. NHA-A stated that dietary staff should be cleaning areas after dinner, and that education would be provided to staff.</p> <p>No additional information was provided.</p> <p>20483</p> <p>* On 12/9/24, at 12:19 p.m. Surveyor observed there is a brown water stain on the ceiling tile leading from the 2 South unit into the 2 East [NAME] unit covering approximately one third of the ceiling tile.</p> <p>* On 12/9/24, at 12:29 p.m., Surveyor observed there are multiple scattered pieces of cereal on the piano as well as the piano bench which is located in the 2 South dining room.</p> <p>On 12/9/24, at 2:11 p.m., Surveyor observed there is still multiple scattered pieces of cereal on the piano and piano bench.</p> <p>* On 12/9/24, at 12:32 p.m., on the wall located between R20 & R21's rooms there are four metal pieces on the wall which appeared to have hung a picture from. The bottom two pieces are approximately six inches above the hand rail and are approximately 1/4 inch in size.</p> <p>On 12/10/24, at 4:11 p.m., Surveyor observed the four metal pieces are still on the wall between R20 & R21's rooms.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/11/24, at 8:12 a.m. Surveyor observed the four metal pieces are still on the wall between R20 & R21's rooms.</p> <p>On 12/11/24, at 8:21 a.m., Surveyor asked Maintenance Director-E how he is notified if something needs to be fixed. Maintenance Director-E informed Surveyor slips can be left at the nurses station, can text, or over head page as a last result. Surveyor then showed Maintenance Director-E the four metal pieces sticking out of the wall between R20 & R21's room. Maintenance Director-E informed Surveyor there was a picture there which is probably downstairs broken. Maintenance Director-E informed Surveyor those, referring to the metal pieces, can unscrew.</p> <p>* On 12/10/24, at 12:06 p.m., Surveyor observed a table with one chair without a resident in the 2 South dining room next to the window and close to the kitchenette. Surveyor asked CNA (Certified Nursing Assistant)-D if any residents sit at this table. CNA-D informed Surveyor there isn't any residents currently and asked Surveyor if Surveyor wanted to sit there. Surveyor pulled the chair away from table and observed there is dried white material along the front edge and multiple areas of dried food throughout the chair cushion.</p> <p>* On 12/10/24, at 12:11 p.m., Surveyor observed in the 2 South dining room to the right of the Merry sign there is an over bed table which has dried material throughout the top of the over bed table.</p> <p>* On 12/10/24, at 12:32 p.m., Surveyor observed a blue & white cooler on the floor in the 2 South dining room next to the table with the condiments. The white top of the cooler has orange and brown liquids dried on throughout the entire top of the cooler. Surveyor opened the cooler and observed water with a Styrofoam and plastic cup floating in the water.</p> <p>On 12/10/24, at 4:11 p.m., Surveyor observed the white top of the cooler on the floor in the 2 South dining room still has dried on orange and brown liquid. The cups are still floating in the water inside the cooler.</p> <p>On 12/11/24, at 8:09 a.m., Surveyor observed the white top of the cooler on the floor in the 2 South dining room still has dried on orange and brown liquid. The cups are still floating in the water inside the cooler.</p> <p>On 12/11/24, at 8:36 a.m., Surveyor asked DON (Director of Nursing)-B who is responsible for the coolers. DON-B replied nursing & dietary, want to say nursing. Surveyor asked DON-B who cleans the coolers. DON-B replied the CNAs. Surveyor informed DON-B of the white & blue cooler which had dried on orange & brown liquid throughout the top and inside there were cups floating in the water.</p> <p>* On 12/10/24, at 4:08 p.m., Surveyor observed in the hallway outside the 2 South dining room above the no smoking sign there are four ceiling tiles with brown water stains. One tile was observed to be covered with approximately one third of the tile with the water stain, the 2nd tile is approximately 75 to 80% covered, the 3rd tile has a small brown water stain and the 4th ceiling tile is covered approximately 20% with a water stain.</p> <p>On 12/11/24, at 8:36 a.m., Surveyor showed Maintenance Director-E the stained ceiling tiles outside the 2 South dining room and also informed Maintenance Director-E of the ceiling tile near the entrance to 2 East-West units and asked if he was aware of the water stains on the ceiling tiles. Maintenance Director-E replied that he was not.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/11/24, at 9:50 a.m., NHA (Nursing Home Administrator)-A, DON-B, and Regional Director-H were informed of the above findings.</p> <p>No additional information was provided</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483</p> <p>Based on interview and record review, the facility did not ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good grooming for 2 (R15 & R11) of 6 residents reviewed for bathing.</p> <p>* R15 & R11 did not consistently receive showers or bed baths.</p> <p>Findings include:</p> <p>The facility's policy titled, Bathing Policy and last revised 11/11/24 under policy documents It is the policy of this facility to provide residents with a bath or shower in order to cleanse the skin, observe the skin, increase circulation, and prevent infection.</p> <p>Under Guidelines documents 1. All residents are offered a bath or shower at least twice a week. 2. If a resident requires a bed bath, a complete bed bath is given two times per week. 3. Residents are encouraged to do as much of their bathing as possible. 4. Documentation of the resident's shower or bath must be completed. If the resident refuses the shower/bath, the nurse needs to be informed for reapproach. If the resident continues to refuse, the refusal must be documented by the licensed nurse.</p> <p>1.) R15's diagnoses includes peripheral vascular disease, diabetes mellitus, coronary artery disease, bipolar disorder, and vascular dementia. R15's power of attorney for healthcare was activated on 9/26/22.</p> <p>The ADL (activities daily living) self care performance deficit care plan initiated 10/3/22 & revised 8/16/24 documents the following interventions for bathing/showering:</p> <p>* Bathing/Showering: Assist x (times) 1. Initiated 10/4/22 & revised 12/4/24.</p> <p>* Bathing/Showering: Avoid scrubbing & pat dry sensitive skin. Initiated 10/4/22 & revised 5/23/24.</p> <p>* Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 10/4/22.</p> <p>R15's physician order dated 11/6/23 documents: Resident shower/bathing twice weekly. Document yes if accepted and no if resident refuses shower/bath. With refusals provide encouragement and reapproach. Document in nursing progress note the interventions provided every day shift every Sat (Saturday) and every evening shift every Wed (Wednesday).</p> <p>R15's Annual MDS (minimum data set) with an assessment reference date of 10/11/24 has a BIMS (brief interview mental status) score of 14 which indicates R15 is cognitively intact. R15 is assessed as requiring substantial/maximal assistance for shower/bathing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The CNA (Certified Nursing Assistant) Kardex dated 12/9/24 under bathing section documents: *Bathing- Sat (Saturday) AM (morning), Wed (Wednesday) PM (evening). *Bathing/Showering: Assist x 1. *Bathing/Showering: Avoid scrubbing & pat dry sensitive skin.</p> <p>On 12/9/24, at 3:05 p.m., during the end of the day meeting with NHA (Nursing Home Administrator)-A & DON (Director of Nursing)-B Surveyor inquired where in the medical record Surveyor would be able to locate when a resident receives a shower/bath. Surveyor was informed in the POC (plan of care).</p> <p>R15's medical record documents that R15 did not receive a shower/bathing on Saturday, 10/5/24 during the day shift, Wednesday, 10/9/24 during the evening shift, Wednesday, 10/16/24 during the evening shift, Saturday, 11/2/24 during the day shift and Saturday, 11/30/24 during the day shift.</p> <p>Surveyor was not able to locate in R15's progress notes R15 refused a shower/bath for the above dates.</p> <p>On 12/10/24, at 11:37 a.m., Surveyor asked CNA (Certified Nursing Assistant)-D if R15 takes a shower. CNA-D informed Surveyor R15 is very particular and there was only one young lady that R15 would allow to give him a shower and she is no longer at the facility. CNA-D informed Surveyor she has to give him a bed bath.</p> <p>On 12/10/24, at 11:49 a.m., Surveyor met with ADON (Assistant Director of Nursing)-C to discuss R15. DON-B was with ADON-C. Surveyor asked if a resident refuses their shower/bath is this documented in the residents record. ADON-C informed Surveyor they should be and if the resident refused what they did. Surveyor provided ADON-C & DON-B with the dates Surveyor was unable to locate R15 received a shower/bath. ADON-C informed Surveyor this is something they will have to look into.</p> <p>On 12/11/24, at 8:18 a.m., Surveyor asked LPN (Licensed Practical Nurse)-G who is responsible for ensuring that residents receive their shower/bath. LPN-G informed Surveyor the nurse on the floor will communicate with the CNA and document whether a shower was given or not.</p> <p>On 12/11/24, at 8:27 a.m., Surveyor observed R15 sitting in a wheelchair in the door way of R15's room. Surveyor asked R15 if he receives a shower. R15 replied no. Surveyor then asked R15 if he receives a bed bath. R15 shook his head no Surveyor asked R15 if he knows why he doesn't receive either a shower or bed bath. R15 shook his head no.</p> <p>On 12/11/24, at 8:42 a.m., Surveyor asked DON-B who ensured residents receive their scheduled showers/baths. DON-B informed Surveyor the floor nurse should be checking in with the CNA. The shower days are on the CNA Kardex so they know who is getting baths either on the day or evening shift. DON-B informed Surveyor the CNA charts when done and the CNA should be calling the nurse when giving a bed bath/shower. Surveyor informed DON-B Surveyor was unable to locate either R15 received a bed bath or refused on 10/5/24, 10/9/24, 10/16/24, 11/2/24 & 11/30/24.</p> <p>No further information was provided to Surveyor regarding R15 not receiving bed baths or showers on the above dates.</p> <p>2.) R11 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - 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** 47094</p> <p>Based on observation, interview, and record review, the facility did not ensure the safety of 4 of 7 residents (R12, R14, R15, R13) reviewed for accidents.</p> <p>* R12 was transferred not according to the care plan and sustained a laceration to the lower left extremity requiring 17 stitches when staff performed a pivot transfer instead of using a Hoyer lift per R12's care plan.</p> <p>* R14 sustained falls on 10/24/2024, 10/25/2024, and 10/29/2024 that were not thoroughly investigated. The intervention for R14's fall on 10/29/2024 was not revised on care plan until 11/7/2024.</p> <p>* R15 sustained falls on 9/11/2024, 9/15/2024, and 9/20204 that were not thoroughly investigated. R15's Wanderguard bracelet was not placed on the wheelchair according to the company manual for the Wanderguard bracelet.</p> <p>* R13 care plan and Kardex indicated the need for assistance with ambulation greater than 50 feet and dependent on staff for up to 150 feet. On 11/8/2024, R13 walked across the street to a restaurant; the facility did not conduct an assessment for R13 to determine if it was safe or not for R13 to do so.</p> <p>R12 is being cited at severity level 3 (actual harm). R14, R15 and R13 are being cited at severity level 2 (potential for more than minimal harm).</p> <p>Findings include:</p> <p>The facility policy titled Resident Transfer Policy revised on 2/1/2024 documents: The Resident Transfer Policy exists to ensure a safe working environment for residents and care giver. Initial screening will be performed on all residents to assess transfer & (and) ambulation status.</p> <ul style="list-style-type: none"> - Therapy and/or nursing will assess each resident to ascertain transfer needs. - Resident transfer and ambulation status will be reviewed via care-plan time frame and on an as needed basis. - Resident transfer status will be found in PCC (Point Click [NAME]- electronic medical record) to inform the staff of appropriate technique to use. <p>Transfers:</p> <p>The transfers will be designated into one of the following categories:</p> <ul style="list-style-type: none"> - Independent - 1 (one) person transfer <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- 2 (two) person transfer</p> <p>- Sit to Stand = 2 caregivers required</p> <p>- Sling Lift (Hoyer) (requires 2 caregivers)</p> <p>Caregivers can always use a device that gives more assistance if required for the safety of the resident but must inform the nursing staff of this change from the care plan .</p> <p>The facility policy titled Fall Policy reviewed on 7/17/2024 documents:</p> <p>POLICY STATEMENT: All residents will receive adequate supervision, assistance, and assistive devices to prevent falls. Each resident will be evaluated for safety risks, including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in preventing falls. All falls are to be investigated and monitored.</p> <p>PROCEDURE:</p> <p>1. INVESTIGATIVE GUIDELINES: .</p> <p>f. Complete Incident/ Event Report</p> <p>g. Obtain detailed statements from ANY [sic] witnesses.</p> <p>2. Quality Assurance Guidelines:</p> <p>a. Review Incident report for completeness</p> <p>b. Complete Investigative Report</p> <p>c. Take the incident to Stand up meeting for review and care plan review .</p> <p>e. The care plan is to be updated with any new interventions .</p> <p>h. The Interdisciplinary Plan of Care (IPOC) team will meet within the same period and discuss the causative factors, interventions to prevent another fall, make therapy referral as necessary, and revise the care plan if necessary .</p> <p>1.) R12 was admitted to the facility on [DATE] with diagnoses that include Dementia and venous insufficiency.</p> <p>R12's quarterly minimum data set (MDS) dated [DATE] indicated R12 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0. The facility assessed R12 needing total assist for pivot transfers, repositioning with 1 staff member, and used a wheelchair dependent on a staff member for transporting in the facility.</p> <p>Surveyor reviewed a facility self-report submitted on 11/24/2024 regarding an injury of unknown origin for R12 that happened during a transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/24/2024 at 21:07 (9:07 PM), in the progress notes, nursing documented that Certified Nursing Assistant (CNA)-Z called Licensed Practical Nurse (LPN)-N to R12's bedroom because R12 had a leg wound that needed to be looked at. LPN-N documented R12 was sitting on the edge of the bed, R12 had no facial grimacing or indication of pain. R12's left lower leg was bleeding and there was a gash noted on the left lower leg. LPN-N asked CNA-Z what happened and CNA-Z replied CNA-Z did not know what happened. LPN-N called for an ambulance to transport R12 to the hospital for further evaluation.</p> <p>On 11/25/2024 at 00:36 (12:36 AM), in the progress notes, nursing documented R12 returned to the facility at 2345 (11/24/2024 at 11:45 PM) and was treated at the hospital for a laceration to the left lower extremity that required 17 stitches.</p> <p>The facility self-report also documents R12 was not transferred according to R12's care plan.</p> <p>Surveyor reviewed R12's ADL (Activities of Daily Living) self-care performance deficit r/t (related to) weakness and advancing dementia care plan that had the following intervention for transfers:</p> <p>-TRANSFER: the resident (R12) requires Mechanical Hoyer Lift with assistance of 2 staff for transfers (initiated/revision 11/15/2024)</p> <p>Surveyor noted a prior resolved intervention for R12's transfer status:</p> <p>-RESOLVED: TRANSFER: the resident (R12) requires assistance by 1 staff to move between surfaces. (initiated 8/2/2023, resolved/ revised on: 11/15/2024)</p> <p>Surveyor reviewed R12's CNA Care Kardex and documented the following for R12's transfer status:</p> <p>-TRANSFER: the resident requires Mechanical Hoyer Lift with assistance of 2 staff for transfers.</p> <p>Surveyor reviewed staff statements collected for the facility self-report:</p> <p>On 11/24/2024, CNA-Z documented in a statement that CNA-Z asked CNA-M to assist with a transfer for R12 to put back into R12's bed. CNA-Z documented CNA-Z was in back of R12 and CNA-M was on the side and assisted R12 into bed. CNA-Z noted blood on the left lower leg. CNA-Z documented CNA-Z went to get the nurse and CNA-M stayed in the room with R12. CNA-Z documented that blood was not observed on R12's bed rail or the wheelchair and that CNA-Z was unsure of what could have happened to cause R12's injury.</p> <p>Surveyor noted that CNA-Z is no longer employed at the facility and was unable to be reached for an interview.</p> <p>On 11/24/2024, CNA-M documented in a statement CNA-M assisted CNA-Z with a pivot transfer for R12 from the wheelchair to the bed. CNA-M stated CNA-M went to put R12's feet into the bed but noted blood on R12's leg. CNA-M checked the wheelchair and bed but did not see anything sharp.</p> <p>On 11/24/2024 at 19:48 (7:48PM), LPN-N documented in a statement that LPN-N was called to the room by CNA-Z regarding R12's leg bleeding. LPN-N asked R12 what happened. LPN-N documented R12 was unable to verbalize what occurred and just pointed to a side table. LPN-N called for transport to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/9/2024 at 3:56 PM, Surveyor interviewed CNA-M who stated CNA-M was asked to assist with a transfer for R12. Surveyor asked what kind of transfer was performed for R12. CNA-M stated that CNA-M and CNA-Z pivoted R12 from the wheelchair to the bed. Surveyor asked if CNA-M knew what kind of transfer R12 was. CNA-M stated that CNA-M did not know what kind of transfer R12 was but that CNA-Z request help with a pivot transfer for R12. Surveyor asked CNA-M if at any time during the transfer if R12 called out or said something while being transferred. CNA-M stated CNA-M did not recall R12 making a noise during the transfer or indicate R12 had any pain. Surveyor asked CNA-M where staff find information on the residents needs such as how a resident transfers. CNA-M stated that all nursing staff have the CNA care Kardex for each resident, staff can also look in PCC on the resident's chart, and also noted on the care plan for nursing staff. Surveyor asked how staff are notified if a transfer status for a resident has changed. CNA-M stated that staff should always look at the CNA care Kardex before caring for the resident, shift report, and in PCC again for any changes.</p> <p>Surveyor asked CNA-M if CNA-M was aware of what R12's transfer status was. CNA-M stated that R12 was not on her resident list and was only helping CNA-Z with the transfer and that CNA-M did not check to see how R12 transferred before helping CNA-Z. Surveyor asked if CNA-M noted anything that could have cut R12's leg. CNA-M stated that CNA-M looked at the wheelchair and bed and there was not anything sharp that CNA-M could see.</p> <p>On 12/10/2024, at 12:04 PM Surveyor interviewed LPN-N who stated LPN-N was called to the room because R12 was bleeding and LPN-N noted a cut on R12's leg. LPN-N stated LPN-N called for transport to the hospital to get it evaluated. LPN-N could not tell what R12 could have cut R12's leg on, the wheelchair and bed looked fine. Surveyor asked LPN-N if LPN-N knew how R12 was to be transferred at the time of the incident. LPN-N stated that it could be found on R12's care plan, and CNA Kardex. LPN-N could not recall what R12's transfer status was but believed it was a Hoyer lift. LPN-N could not recall if CNA-Z asked LPN-N about R12's transfer status on 11/24/2024.</p> <p>On 12/10/2024, at 12:09 PM, Surveyor interviewed R18 who was R12's roommate on 11/24/2024. Surveyor asked R18 if R18 recalled R12 and the incident on 11/24/2024. R18 remembered R12 and the incident on 11/24/2024. R18 stated that 2 staff members transferred R12 from R12's wheelchair to the bed. Surveyor asked if R12 made any noise during the transfer or indicated that R12 was hurt. R18 remembers R12 yelling out because it startled R18 and when R18 looked over R18 noted R12 mouth open and was making a crying noise. Surveyor asked if staff could see what R12 cut herself on. R18 stated that it may have been something on the wheelchair because R12 called out when the staff member helped R12 stand out of the wheelchair, but no one could tell what could have cut R12.</p> <p>On 12/10/2024, at 12:25PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who stated CNA care Kardex's are available on all units and updated with all changes. ADON-C stated staff can also view the residents PCC for transfer status among other care information and are to look at it before all care with a resident every time staff is on the unit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/20/2024, at 3:08 PM, Surveyor shared concerns with nursing home administrator (NHA)-A, DON-B, Regional Director- H and Director of Quality Assurance-L regarding R12 not being transferred according to R12's care plan. R12 was transferred using a pivot transfer instead of a Mechanical Hoyer lift transfer and sustained an injury to R12's left lower leg requiring 17 stitches. Regional Director- H stated that the facility investigated the incident with R12 on 11/24/2024 and noted that R12 was not transferred according to R12's care plan and the facility completed a 4 (four) point plan and brought it to their Quality Assurance and Performance Improvement (QAPI) Committee. Surveyor stated if offered, Surveyor would look at the plan.</p> <p>On 12/11/2024, at 7:47AM, Surveyor reviewed the facility's 4 point/ QAPI plan for R12's incident on 11/24/2024.</p> <p>On 12/11/2024, at 8:58AM, Surveyor interviewed Maintenance Director-E. Surveyor asked if Maintenance Director-E was asked to look at R12's bed or wheelchair to see if there were concerns of anything on the bed or wheelchair that could have caused the laceration to R12's left lower extremity. Maintenance Director-E could not recall but would check notes and orders.</p> <p>On 12/11/2024, at 9:15AM, NHA-A stated that NHA-A looked at R12's wheelchair and that NHA-A has directed Maintenance Director-E to look at R12's bed and wheelchair. NHA-A stated that there were not areas on the wheelchair that could have cause the type of laceration R12 had, however there were some areas that may have been a little rough so R12's wheelchair was swapped out for another wheelchair. NHA-A stated R12's bed was fine, and no areas of concern were noted.</p> <p>On 12/11/2024, at 9:51AM, Surveyor shared with NHA-A, DON-B, Regional Director- H and Director of Quality Assurance-L that the 4 point QAPI plan was reviewed however there were other concerns that R12 was harmed when transferred not according to R12's plan of care and that R12 required 17 stitches to R12's left lower extremity.</p> <p>On 12/11/2024, at 10:54 AM, Maintenance director-E stated that R12's wheelchair and bed were looked at and there were no concerning areas found, however the facility gave R12 a new wheelchair to avoid any other issues.</p> <p>2.) R14 was admitted to the facility on [DATE] and has diagnoses that include rhabdomyolysis, type 2 diabetes mellitus, peripheral vascular disease, major depressive disorder, hearing loss, and a history of falling.</p> <p>R14's admission minimum data set (MDS) dated [DATE] indicated R14 has severely impaired cognition with a brief interview for mental status (BIMS) score of 6 and the facility assessed R14 needing moderate assist with 1 staff member using a gait belt and two wheeled walker up to ten feet, toileting hygiene, lower body dressing, and putting on and off footwear.</p> <p>R14's fall risk was assessed as a high risk with a score of 12.0 on 10/14/2024.</p> <p>R14's fall care area assessment dated [DATE] documents that R14 triggered for falls related to a history of falls and other contributing factors including physical deconditioning, rhabdomyolysis, diabetes, hypertension, and impaired mobility. A plan of care was initiated to continue to monitor and prevent falls. Implementation to include fall precautions in place such as: frequent checks, ensure R14's call light is within reach, make sure gripper socks are on, and safety reminders.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R14's at risk for falls care plan was initiated on 10/14/2024 with the following interventions:</p> <ul style="list-style-type: none"> - Be sure the resident's call light is within reach and encourage the resident to use it for assistance and as needed. - Ensure that the resident is wearing appropriate footwear, and that footwear is donned appropriately. (revised on 10/24/2024) - Educate the resident/ family/ caregivers about safety reminders and what to do if a fall occurs. - Follow facility fall protocol. - PT (physical therapy) evaluate and treat as ordered and PRN (as needed). - Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/ remove any potential causes if possible. Educate resident/ family/ caregivers/ IDT (Interdisciplinary Team) as to cause. - The resident needs activities that minimize the potential for falls while providing diversion and distraction. - Fall mat at bedside (initiated 10/25/2024) - Encourage resident to have bed in lowest position while in bed. Resident refuses at times, educate on risks versus benefits of this intervention, continue to provide reminders on the importance of keeping bed in low position. (initiated 10/25/2024, revision on 12/3/2024) - Educate and encourage resident to wait for staff assistance after pressing call light before attempting to ambulate. (initiated 11/7/2024) <p>On 10/24/2024, at 12:14 PM, in the progress notes Assistant Director of Nursing (ADON)-C documented R14's roommate notified nurse roommate heard R14 fall in the bathroom. ADON-C went to R14's room and asked what happened. ADON-C documented R14 stated R14 slipped because R14's gripper socks were on upside down with the grippy part on top of the foot and the cloth part on the bottom of the foot.</p> <p>On 10/25/2024, at 3:24 AM, in the progress notes licensed practical nurse (LPN)-HH documented that LPN-HH walked into R14's room and observed R14 lying on the floor on R14's left side. R14 stated R14 was attempting to get in the wheelchair.</p> <p>On 10/29/2024 at 15:13 (3:13 PM), in the progress notes nursing documented: R14 found sitting on R14's bottom parallel to R14's bed. R14 stated R14 turned on the call light and got up to use the bathroom and when got back from the bathroom was not back against R14's bed enough and slid to the floor.</p> <p>On 12/9/2024, at 12:05 PM, Surveyor observed R14 lying in bed waiting for lunch. Surveyor asked if R14 has had any falls while at the facility. R14 stated when R14 first got to the facility R14 fell a couple of times, but now waits to get help before getting up. R14 did not recall details about the falls on 10/24/2024, 10/25/2024, and 10/29/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/10/2024, Surveyor reviewed the fall investigation for R14's falls on 10/24/2024, 10/25/2024, and 10/29/2024 and noted the following concerns.</p> <ul style="list-style-type: none"> - There are no staff statements documenting the events leading up to R14's falls. - There are staff statements documenting when R14 was last observed and toileted prior to R14's falls. - R14's fall care plan was not revised until 11/7/2024 after R14's fall on 10/29/2024. <p>On 12/10/2024, at 12:22 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C regarding R14's fall on 10/24/2024. ADON-C recalls R14 sitting on R14's bed and was notified of R14's fall right away. ADON-C does not feel it was a long time between when the roommate notified staff of R14's fall and when R14 was assessed. Surveyor asked if ADON-C knew when R14 was last seen, toileted or if anyone was interviewed about R14's falls on 10/24/2024, 10/25/24, and 10/29/2024. ADON-C stated ADON-C did not know when R14 was last seen or toileted by staff and does not recall interviewing anyone regarding R14's falls.</p> <p>Surveyor informed ADON-C that R14's fall care plan was not revised until 11/7/2024 after R14's fall on 10/29/2024. Surveyor asked what the expectation for care plan revision was. ADON-C stated that R14's care plan should have been revised after R14's fall on 10/29/2024 and should not have been done on 11/7/2024. Surveyor informed ADON-C that R14 pushed the call light for help on 10/29/2024 but went to the bathroom without assistance due to having to wait and no staff arriving. Surveyor asked ADON-C if this lack of assistance was investigated, or any staff were interviewed to determine when R14 pushed the call light and how long R14 was waiting before R14 walked to the bathroom alone. ADON-C was not sure how long R14 was waiting after R14 pushed the call light and could provide no additional information.</p> <p>On 12/10/2024, at 2:21 PM, Surveyor interviewed LPN-HH who stated on 11/25/2024 LPN-HH recalled R14 was restless and kept trying to get out of the bed. LPN-HH stated staff kept trying to reorient R14 to the time of day and that it was still nighttime and R14 should sleep. LPN-HH stated it was the first time LPN-HH had R14 and was not sure what R14's baseline was so not sure if the behaviors were new for him but now that LPN-HH has cared for R14 more LPN-HH is aware the restlessness was not R14's baseline. LPN-HH was not sure when the last time staff observed or toileted R14 before the fall on 10/25/2025. LPN-HH stated after the fall, R15 stayed in bed and there were no further issues.</p> <p>Surveyor noted that there was not indication that the facility investigated why R14 was restless or kept wanting to get out of bed.</p> <p>On 12/10/2024, at 3:08 PM Surveyor shared concerns with Nursing Home Administrator (NHA)-A, DON-B, Regional Director-H and Director of Quality Assurance- L that R14's falls on 10/24/2024, 10/25/2024, and 10/29/2024 were not thoroughly investigated and did not include staff statements of when R14 was last observed or toileted, why R15 was restless and trying to get out of bed on 10/25/2024, and R14's care plan was not revised until 11/7/2024 after R14's fall on 10/29/2024. No additional information was provided.</p> <p>20483</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>3.) R15's diagnoses include hemiplegia & hemiparesis following unspecified cerebrovascular disease affecting left dominate side, left above knee amputation, diabetes mellitus, seizure disorder, bipolar disorder, and vascular dementia. R15's power of attorney for healthcare was activated on 9/26/22.</p> <p>R15's risk for falls care plan initiated 10/3/22 & revised 8/16/24 documents the following interventions:</p> <ul style="list-style-type: none"> * Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Initiated 10/4/22. * Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Initiated 10/4/22. * Follow facility fall protocol. Initiated 10/4/22 & revised 1/11/23. * PT (physical therapy) evaluate and treat as ordered or PRN (as needed). Initiated 10/4/22. * Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. Initiated 10/4/22. * Place call don't fall sign in room. Initiated 1/2/23 & revised 5/23/24. * Floor pad next to side of bed, when in bed. Initiated 1/4/23 & revised 8/6/24. * Medication review. Initiated 1/4/23. * Encourage to follow smoking schedule and remind resident of smoking times. Initiated 1/25/23 & revised 8/6/24. * Offer and assist to bed between lunch and dinner as desired. Initiated 3/1/23. * Soft touch call light. Initiated 3/14/23. * Resident remains 1 assist but continues to self-transfer, therapy to evaluate for safety. Initiated 8/10/23. * Hx (history) of self-transferring to and from bed. Requested made for therapy to eval (evaluate) for education and work on self-transfers to reduce falls. Resident is a 1 assist, reviewed fall history and continues to try and self-transfer despite education. Initiated 8/14/23 & revised 5/23/24. * Refer to therapy for eval and treat for transfer safety. Initiated 3/27/24. * Apply anti-roll backs to wheelchair. Initiated 3/28/24. * Therapy recommendations for restorative program including transfer training and AROM (active range of motion) for upper and lower extremities. Initiated 4/1/24. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> * Evaluate height of bed for safe transfers. Initiated 4/1/24 & revised 5/23/24. * Apply break extenders to bilateral brakes on wheelchair (applied but resident habitually removes these). Initiated 4/17/24 & revised 9/25/24. * Frequent monitoring in between smoking times. Initiated 5/17/24. * Enabler bars to assist with transfers and positioning in bed. Initiated 8/6/24. * Encourage resident to use call light to request staff assistance prior to attempting to self-transfer. Initiated 8/6/24. * Educate family on ETOH (alcohol) usage. Initiated 9/24/24. <p>R15's event note dated 9/11/24, at 17:07 (5:07 p.m.), documents: Situation: CNA (Certified Nursing Assistant) informed writer patient was sitting on his fall mat. It appeared he had slid himself out of bed. Vitals taken and they were stable, pupils equal and reactive, no signs of bleeding MD (medical doctor) called. POA (power of attorney) notified Recommendations: MD informed writer to keep a close eye on patient and call if anything changes. This note was written by LPN (Licensed Practical Nurse)-F.</p> <p>R15's nurses note dated 9/14/24 at 09:52 (9:52 a.m.) documents Resident on board for an unwitnessed fall. Resident stable, VSS (vital signs stable), resident has no complaints of pain or discomfort. This nurses note was written by RN (Registered Nurse)-DD.</p> <p>R15's nurses note dated 9/15/24 at 22:15 (10:15 p.m.) documents found resident on the floor on the mat sitting on his bottom no c/o (complaint of) pain or discomfort no injury seen neuro (neurological) started [Name] and POA notified. This nurses note was written by LPN-EE.</p> <p>R15's late entry nurses note dated 9/20/24 at 1500 (3:00 p.m.) created on 9/23/24 at 1655 (4:55 p.m.) documents Resident was attempting to transfer himself from bed into wheelchair, but the resident did not lock the wheels on his wheelchair, so when attempting to transfer, the chair rolled back and the resident fell on the floor. No injuries noted. Resident denies hitting his head. This nurses note was written by UM (Unit Manager)-FF.</p> <p>R15's fall risk assessment dated [DATE] has a score of 11 which indicates high risk for falls.</p> <p>R15's annual MDS (minimum data set) with an assessment reference date of 10/11/24 has a BIMS (brief interview mental status) score of 14 which indicates cognitively intact. R15 is assessed as not having any behavior. Assessed as being independent for rolling left and right, and requires partial/moderate assistance for chair/bed to chair transfer & toilet transfer. R15 is assessed as always being incontinent of urine and bowel. R15 has not had any falls since prior assessment period which was a medicare 5 day with an assessment reference date of 9/23/24.</p> <p>The fall CAA (care area assessment) was not triggered.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aria of Brookfield		STREET ADDRESS, CITY, STATE, ZIP CODE 18740 W Bluemound Rd Brookfield, WI 53045	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The CNA Kardex as of 12/9/24 under safety section documents *Floor pad next to bed, when in bed. *Frequent monitoring in between smoking times. *Monitor exit seeking behavior. *Nurse cart has cigarettes and lighter in locked box. *Requires supervision while smoking.</p> <p>On 12/9/24 at 11:32 a.m., Surveyor observed R15 in bed on the back with the head of the bed elevated. There is a transfer bar on each side of R15's bed and a gray floor mat on the left side of R15's bed. There is green sign on the wall on the right side of the bed which documents Call Don't fall.</p> <p>On 12/9/24 at 12:36 p.m., Surveyor observed R15 in bed eating lunch.</p> <p>On 12/9/24 at 3:05 p.m., during the end of the day meeting with NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B, Surveyor asked for the complete investigation for R15's falls on 9/11/24, 9/15/24, & 9/20/24.</p> <p>On 12/9/24 at 3:41 p.m., Surveyor observed R15 in bed on his back with the head of the bed elevated. Surveyor observed the call pad is hanging down on the right side of the bed and not within reach. The gray floor mat is on the left side of the bed and transfer bars up on R15's bed.</p> <p>On 12/10/24 at 8:16 a.m., Surveyor observed R15 in bed on his back with his eyes closed. Surveyor observed the transfer bars are up, there is a gray mat on floor on the left side of R15's bed, the call pad is hanging down on the right side and is not within reach.</p> <p>On 12/10/24 at 9:09 a.m., Surveyor reviewed the fall information provided for R15's fall on 9/11/24 when R15 slid from the bed onto the floor which included resident fall data dated 9/11/24. This resident fall data includes a question for last time toileted or incontinence cares given & was the call light activated which were not completed. The section for witness statements obtained by all staff working on the unit is not completed nor were there any witness statements provided. An event note dated 9/11/24, an order dated 9/12/24 for PT/OT (physical therapy/occupational therapy) eval/treat for falls and an IDT (interdisciplinary team) note dated 9/13/24 was also provided. Surveyor noted the Facility did not conduct a thorough investigation as there are no staff interviews as to who last saw R15, when incontinence cares were provided to R15, etc. The Facility did not determine a root cause and did not revise R15 care plan until 9/24/24 or did not indicate the fall interventions were appropriate when R15 fell on [DATE].</p> <p>On 12/10/24 at 9:11 a.m., Surveyor reviewed the fall information provided for R15's fall on 9/15/24 when R15 slid from the bed to the mat on the floor. This information included resident fall data dated 9/15/24 which includes a question for last time toileted or incontinence cares given. The section for witness statements obtained by all staff working on the unit is not completed nor were there any witness statements provided. Also provided was a nurses note dated 9/16/24, [managed care name] note dated 9/16/24, an IDT note dated 9/17/24, [managed care name] note dated 9/17/24, and Basic Metabolic Panel result dated 9/14/24.</p> <p>Surveyor noted the facility did not conduct a thorough investigation as there are no staff interviews as to who last saw R15, when incontinence cares were provided to R15, etc. The facility did not determine a root cause and did not revise R15 care plan until 9/24/24 or did not indicate the fall interventions were appropriate when R15 fell on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/10/24 at 9:15 a.m., Surveyor reviewed the fall information provided for R15's fall on 9/20/24 when R15 fell when attempting to transfer into the wheelchair. Surveyor was provided only with an incident report. Under incident description for nursing description documents Resident was attempting to transfer himself from bed into his wheelchair, but the resident did not lock the wheels on his wheelchair, so when attempting to transfer, the chair rolled back and the resident fell on to the floor. No injuries noted. Under resident description documents Resident sated he was trying to get into his wheelchair, and the wheelchair rolled back when he was trying to transfer, so he fell on to his butt on the floor.</p> <p>Surveyor noted the facility did not conduct a thorough investigation as there are no staff interviews as to who last saw R15, when incontinence cares were provided to R15, etc. R15's care plan was not revised until 9/24/24.</p> <p>On 12/10/24 at 11:53 a.m., Surveyor met with ADON (Assistant Director of Nursing)-C with DON (Director of Nursing)-B. Surveyor informed ADON-C of R15's three falls on 9/11/24, 9/15/24, & 9/20/24. Surveyor informed ADON-C there are no staff statements or indications staff were interviewed, the fall information provided to Surveyor does not include who last saw R15, when was incontinence cares provided etc and the care plan was not revised until 9/25/24. Surveyor asked ADON-C for any additional information for R15's three falls.</p> <p>On 12/10/24 at 3:22 p.m. during the end of the day meeting NHA (Nursing Home Administrator)-A, DON-B, Regional Director-H, and Director of Quality Assurance-L were informed R15 had three falls on 9/11/24, 9/15/24, & 9/20/24. There is no evidence of a thorough investigation for these falls as the information provided to Surveyor doesn't include staff statements or indicates staff was spoken to as to who last saw R15, when was R15 provided with incontinence cares etc, what was R15 trying to do etc. There is no root cause and the care plan was not revised until 9/25/24. Surveyor asked to be provided with any additional information regarding R15's falls.</p> <p>On 12/11/24 at 8:37 a.m., Surveyor asked DON-B to explain the process when a resident falls. DON-B explained the nurse will do an assessment, for any skin or injury with the fall, vitals, and getting the resident in a safe position transferring with a hoier. The MD, POA, Guardian will be contacted. If the resident is their own person will ask if they want the emergency contact contacted. If the resident hits their head they will be sent out to the hospital. The risk management and falls packet will be completed. Surveyor inquired who completes these. DON-B informed Surveyor the floor nurse. DON-B informed Surveyor the floor nurse is responsible for getting staff statements. DON-B informed Surveyor the fall packet is given to her. Surveyor inquired who determines the root cause. DON-B replied that would be me.</p> <p>The WanderGuard departure alert system user & installation manual for the section Component Descriptions-Bracelets under warning includes documentation of Do not place the bracelet on or next to metal, such as wheelchair frames, jewelry, watches, etc., or allow it to come in contact with a metal door or associated hardware such as crash bars, push bars, etc. Metal could interfere with the signal sent from the bracelet to the door antennas and result in an unauthorized departure.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The WanderGuard System Operation - Bracelet Activation and Use section on page 17 under Bracelet Placement documents WanderGuard bracelets (model 36000 series) should be placed on the residents dominate wrist. The metal in a wheelchair frame (or any metal items) may interfere with the bracelet's signal to the door modules. Before proceeding with alternate placement, you must contact Technical Service for further instructions. Your bracelet placement protocol needs to define the standard		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>20483</p> <p>Based on observation, interview, and record review, the facility did not provide the necessary respiratory care and services for 1 (R17) of 3 residents receiving oxygen therapy.</p> <p>* R17's oxygen humidification bottle was observed to be empty or dry.</p> <p>Findings include:</p> <p>The facility's policy titled, Oxygen Administration with no date, documents: Oxygen will be safely administered per physician orders. Under the mask section includes documentation of If humidification is used, change humidifier bottle every 7 days or as needed. May label with date and initial. Fill bottle with sterile distilled water as often as needed to keep at proper level marked on bottle.</p> <p>R17's diagnoses include congestive heart failure, chronic respiratory failure with hypoxia, dementia, and anxiety.</p> <p>R17's care plan documents that R17 uses oxygen therapy r/t (related to) CHF (congestive heart failure). Initiated 7/4/24 & revised 8/14/24 documents the following interventions:</p> <p>* Encourage or assist with ambulation as indicated. Initiated 7/4/24.</p> <p>* For residents who should be ambulatory, provide extension tubing or portable oxygen apparatus. Initiated 7/4/24.</p> <p>* Monitor for s/sx (signs/symptoms) of respiratory distress and report to MD (medical doctor) PRN (as needed): Respirations, Pulse oximetry, increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Initiated 7/4/24.</p> <p>* OXYGEN SETTINGS: O2 (oxygen) via nasal prongs @ (at) 4 LPM (liters per minute) Continuous. Initiated & revised 8/14/24.</p> <p>R17's physician orders dated 8/15/24 document: Oxygen Concentrator for supplementary oxygen use via (Nasal Cannula/Mask) at 4L (liters). every shift Monitor O2 sat (saturation) and monitor function of device Y=working N=document issues and tag, replace device O= not used doc (document) why change tubing weekly on Wednesday take out black foam filter from back rinse soap.</p> <p>On 12/10/24, at 8:00 a.m., Surveyor observed R17 in bed on the back with the head of the bed elevated. R17 was observed to be receiving 4 liters of oxygen via nasal cannula. Surveyor asked R17 if there are any problems with staff changing her oxygen tubing. R17 replied no but look, pointing to the humidifier bottle on the wall which is empty/dry. R17 informed Surveyor she only wants tap water in the bottle and doesn't want to smell any chemicals. Surveyor observed R17 is receiving her oxygen from the wall and not an oxygen concentrator. Surveyor asked R17 how long there hasn't been any water in the humidifier bottle. R17 started laughing and then stated for a good while.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/10/24, at 10:03 a.m. Surveyor rechecked R17's humidifier bottle and observed there was still not any water in the bottle and the bottle is dry.</p> <p>On 12/10/24, at 10:09 a.m., Surveyor asked LPN (Licensed Practical Nurse)-F if she knows R17. LPN-F replied I do. Surveyor asked LPN-F if there should be water in R17's oxygen humidifier bottle. LPN-F replied R17 that there should be water in R17's oxygen humidifier bottle. Surveyor informed LPN-F of the observations of R17's oxygen humidifier bottle not have any water.</p> <p>On 12/10/24, at 11:57 a.m., Surveyor asked ADON (Assistant Director of Nursing)-C if there should be water in a residents oxygen humidifier bottle. ADON-C informed Surveyor there should be water in a residents oxygen humidifier bottle. Surveyor informed ADON-C of the observations of R17's humidifier bottle not having any water and observed being dry.</p> <p>On 12/10/24, at 3:22 p.m., NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, Regional Director-H and Director of Quality Assurance-L were informed of the above findings.</p> <p>No additional information was provided to Surveyor as to why R17's oxygen humidifier bottle did not have water.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50700</p> <p>Based on observation, interview and record review, the facility did not maintain legible nurse staffing documents for 39 days. This has the potential to affect all 101 residents currently residing in the facility.</p> <p>* The facility Nurse Staff Posting form does not contain legible documentation in the daily census. This document is found at the front desk of the building and is for staff, residents, and visitors of the facility to know the amount of direct care staff that is currently working at that time or day.</p> <p>Findings include:</p> <p>The facility policy, Staffing Contingency Policy [NAME] Healthcare revised 7/2024 has no information pertaining to direct care staff posted documentation.</p> <p>On 12/10/2024, at 10:48 AM, Surveyor observed [NAME] of [NAME] staffing form, the form had a grid box with 7 boxes vertically and 4 boxes horizontally. The document had black specks and extra lines on the entire cover of document, making it not legible. Surveyor noted that text that is on the paper is not legible due to the box on the form being slanted upward and being cut off the edge of the page on the right side. Surveyor noted that anyone trying to read this form would struggle in understanding as it was not legible.</p> <p>On 12/10/2024, at 10:48 AM, Surveyor observed Direct care staffing forms dated from 11/1/2024 to 12/10/2024 and for all dates that were reviewed, the staffing form was not legible due to the above concerns.</p> <p>On 12/10/2024, at 12:53 PM, Surveyor interviewed Scheduler-O who explained the text from the declaration of direct care staffing. Scheduler-O said it is [NAME] and hard to read, but that she doesn't know where to get a new copy of the form as there is always just copies sitting at the front desk in the morning. Scheduler-O called NHA-A and asked for a new copy of the declaration of direct care staffing.</p> <p>On 12/11/2024, at 08:00, Surveyor received new form Declaration of Direct Care Staffing which was now legible, this was sitting at the workspace of Surveyor upon return to conference room.</p> <p>On 12/11/2024, at 0930 AM, Surveyor observed a new legible form is now at the front desk for the public, residents, and staff to view.</p> <p>On 12/11/2024, at 9:50 AM, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were made aware of the above concerns that the form was not legible and that it was not fixed until after Surveyor brought it to the facility's attention. NHA-A stated that this concern has never been brought up before, but that the facility did replace it after it was brought to the facility's attention.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	No additional documentation was provided as to why the facility did not ensure that it maintained legible nurse staffing documents for 39 days.		