STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525424	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Brookfield	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review and policy review, the facility failed to protect the resident's right to be free from abuse by a family member for one of three residents (Resident (R)17) reviewed for abuse out of a total sample of 23. R17 experienced an altercation with his family member (FM2) during a family visit and FM2 hit R17 on the forehead. Failure to protect resident from abuse had the potential to result in injury to residents. Findings include: Review of the facility's undated policy titled AA Healthcare Abuse Prevention Program Revealed, This facility affirms the right of our residents to be free from abuse, neglect, . or mistreatment. This facility therefore prohibits abuse . and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse . of residents. Review of R17's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed an admitted [DATE] with medical diagnosis of vascular dementia. Review of R17's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 04/01/25, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating R17 was severely cognitively impaired. Review of R17's progress notes under the Prog Notes tab in the EMR, documented on 04/08/25 at 3:15 PM Social worker asked writer to look at resident's forehead. Writer asked resident [what happened], resident replied my [FM2] hit me. The resident was assessed, and the Administrator was made aware. The Administrator informed police and police interviewed the resident. The Nurse Practitioner was here assessed resident's forehead. Resident denied any pain. R17's POA [Power of Attorney] is aware. During an interview on 5/8/25 at 5:43 PM, the Director of Social Services (DOSS) recounted the interview with FM1 about the incident on 04/08/25, when FM2 hit R17 on the forehead. FM1 stated that there was an argument between FM2 and R17. FM2 was very frustrated with R17's behavior/response and threw the television remote at R17 then proceeded to hit him on his forehead. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/25 at 6:30 PM, the Administrator verbalized residents will not experience harm or abuse at the facility.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39540 Based on observation, interview, document review, and policy review, the facility failed to ensure that at the completion of the narcotic count both nurses who participated in the counting documented the accurate count at the change of each shift for three of four medication carts (1 South, 1 East, and 2 South B) reviewed for accuracy of narcotic counts. As a result of this deficient practice, not signing the correct narcotic count creates the potential for misappropriation of narcotics and missed doses for residents. Findings include: Review of the facility policy titled Medication Storage in the Facility: Controlled Substance Storage, revised January 2018, revealed, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state, and other applicable laws and regulations. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented. During an observation on 05/08/25 at 6:05AM, Licensed Practical Nurse (LPN)6 and LPN7 counted the narcotics in the medication cart for 2 South B. LPN6 was going off shift and LPN7 was coming on shift. The process of counting observed, LPN6 had the binder with the pages for each narcotic card/syringe pack and LPN7 looked at the cards for the number of medications left. As LPN7 fingered through the cards, LPN7 announced the number on each card and continued to the next card. Each of the syringes in the plastic bags were also counted, no names of drugs were verbalized or names of residents for whom the medications were prescribed. During an observation on 05/08/25 at 1:00 PM, the narcotic count binder on the medication cart for 2 South B was observed to have missing signatures on the accountability page that records the names/signatures of the nurses who perform the narcotic count at each change of shift. During an observation on 05/08/25 at 12:33 PM with the narcotic count sheets in the binder on the top of the medication cart for 1 South and 1 East, documentation sheets were missing signatures for change of shift counting. During an interview on 05/08/25 at 12:33 PM the Assistant Director of Nursing (ADON), confirmed the observation the count sheets were missing signatures. Each shift change, prior to handing off the keys to the cart, two nurses count the narcotics and there should be six signatures for each date, two for the 6:00AM shift change, two for the 2:00PM shift change and two for the 10:00 PM shift change each day. Review of the narcotic shift count sheets for the medication cart for 1 South revealed, count sheet dated 04/05/25 to 04/16/25, revealed 54 missing signatures, three days in a row with no signature at all. One South narcotic count sheet from 04/17/25 to 05/02/15 revealed 37 missing signatures, and dated 05/02/25 to 05/07/25 were missing four signatures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the narcotic shift count sheets for the medication cart for 1 East revealed, count sheet dated 04/05/25 to 04/16/25, revealed missing 54 signatures including seven days with no signatures. Review of the narcotic shift count sheets for the medication cart for 2 South B revealed, count sheet dated 05/01/25 to 05/07/25, revealed 16 missing signatures. During an interview on 05/08/25 at 1:10 PM, LPN7 confirmed the process used to count the narcotics at 6:00 AM on 05/08/25 was to name only the number of the medication on the card and did not state the type of medication or the name of the resident for which the medication was prescribed. LPN7 then stated, if I named the medication and resident for each one, it would take all day! During an interview on 05/08/25 at 1:10 PM, the ADON confirmed the name of the resident and medication were to be verbalized during the count of narcotics at each change of shift and then the narcotic count sheet was to be signed by both nursing staff who performed the count. During an interview on 05/08/25 at 3:15 PM, the Director of Quality Assurance (QA) and the Director of Nursing (DON) confirmed the narcotic sheets were to be signed after each count, on each cart, at change of shift when the narcotic keys are handed off.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39540 Based on observation, interview, and policy review, the facility failed to ensure medications were secure and medication carts were locked for two of two medication carts observed at the second floor south nursing unit. As a result of this deficient practice medications may be unsecured and available for diversion. Findings include: Observation on 05/08/25 at 5:15 AM, at the nursing station on 2 South, no staff were in sight. A resident was ambulating near the station, and there were 15 medication cards sitting on the desk, out in the open, unsecured. Observation on 05/08/25 at 5:15 AM, at the nursing station on 2 South, no staff were in sight. Two medication carts were parked near the station and both medication carts were unlocked and drawers containing the medications for the residents were able to be opened. During an interview on 05/08/25 at 5:20 AM, Licensed Practical Nurse (LPN)6 confirmed the medications left on the desk were not secured and should have been. They were delivered by the pharmacy at about 4:00 AM and should have been secured when delivered and not left on the desk. LPN6 also confirmed the medication carts should have been locked when unattended and they were not locked and should have been. During an interview on 05/08/25 at 9:25 AM, the Director of Quality Assurance confirmed the medication carts are to be locked when left unattended and medications should not be left on the desk of the nursing station unattended and unsecure. Review of the facility's policy titled Medication Storage in the Facility revised January 2018, revealed, Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications . permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 25490 Based on observations, and interviews, the facility failed to ensure the facility wide security alarm system is communicated throughout the facility when triggered. This failure indicates a critical gap in the alarm system's ability to effectively alert staff facility-wide during a potential security or emergency event. This finding suggests a limitation in the current alarm system's ability to communicate alerts comprehensively across all critical areas within the building which could potentially affect the safety of all residents and staff. Findings include: Observations on 05/08/25 at 5:05 AM two surveyors entered the facility through the front entrance, which was found to be unlocked. Upon entry, a loud screeching noise consistent with an activated alarm was heard. The surveyors proceeded through the main facility lobby, estimated to be approximately 50 yards in length, and entered through a single interior door leading to the first nursing station, identified as One South. Upon arrival at the nursing station, a wall-mounted security panel located on the back wall displayed multiple illuminated indicator lights and emitted a persistent beeping sound, further confirming the alarm activation. No staff were present at the nursing station at 1 south to respond to the facility alarm. Surveyors continued to walk further down the unit on the first floor towards the second nursing station, identified as One East/West. Upon arrival, we observed one Certified Nursing Assistant (CNA) seated at the nursing station. As we moved farther from the initial nursing station (One South), the volume of the alarm noticeably diminished. By the time we reached the One East/West station approximately 250 to 300 yards from the first station, The alarm was no longer audible which was also confirmed by the CNA6. The second surveyor continued to the second floor and was unable to hear any alarm systems. Interview on 05/08/25 at 5:31 AM, Registered Nurse (RN)1 revealed, she was not sitting on 1 south and was passing medications on 1 east/west and could not hear the facility overhead alarm system being triggered. Interview and observation on 05/08/25 at 7:37 AM, the Maintenance Director revealed that the facility overhead security system is not monitored by a security company. He further shared at 8:00 PM the alarm system is armed and requires a code to exit the building until 6:00 AM. During this same time, an observation was made triggering the overhead system and wander guard system and it was determined that there was no breach with the wander guard system. An observation and interview conducted on 05/08/25 at 11:31 AM with the Facility Administrator, Director of Maintenance, Director of Nursing (DON), Director of Quality Assurance (QA) and Chief Information Officer (CIO) revealed the following: When the facility's overhead alarm system is activated, a loud screeching sound is emitted near the front entrance. Additionally, a rapid beeping sound and visual indicator lights are triggered on the alarm panel located at the One South nursing station. They confirmed that there was only audible and visual indicators at the One South nursing unit and that there was no other audible or visual alarm notifications at any of the other nursing stations throughout the facility. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and observations on 05/08/25 at 11:35 AM, the wander guard system was activated. Several facility staff quickly convened to the location to ensure no residents had existed the building. Interview at this time with the facility receptionist, who was stationed at 1 South (where the security system box is located), revealed that the box located on 1 south identified there was a breach at the front entrance. The box will indicate if a wander guard has triggered the front entrance or if the overhead security system has been triggered. However, this information was not relayed to any other units in the facility. During an interview on 05/08/25 at 4:18 PM, the Director of QA revealed that the facility needs to ensure an overhead alarm system capable of audibly and visually notifying all critical care areas, particularly beyond the One South nursing station. This failure could pose a serious risk to residents' health and safety.