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	06/10/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and facility document and policy review, the facility failed to submit an initial report of an allegation of staff-to-resident abuse to the state survey agency within two hours for 1 (Resident #3) of 3 sampled residents reviewed for abuse. Findings included: An undated facility policy titled, Abuse Prevention Program, specified, VII. External Reporting 1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or the designee, shall complete and submit a DQA [Division of Quality Assurance] form F-62617, notifying DQA that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. This report shall be made immediately. The term immediately as it is used in this policy in relation to reporting abuse, neglect, exploitation, mistreatment, misappropriation of resident property, and suspicion of a crime shall defined as, following management of the immediate risk to the resident or residents, including the administration of necessary medical attention, and establishing the safety of the resident or residents involved' or not later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause suspicion do not result in serious bodily injury. An admission Record revealed the facility admitted Resident #3 on 04/24/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic kidney disease and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/03/2025, revealed Resident #3 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision-making and had a short-term and long-term memory problem. The MDS indicated Resident #3 required substantial/maximal assistance with upper body dressing, toileting, and rolling left to right. The MDS indicated Resident #3 was always incontinent of bowel and bladder. Resident #3's Progress Notes, dated 05/02/2025 at 11:30 AM, revealed as a nurse and certified nursing assistant (CNA) turned and dressed Resident #3 for dialysis, the resident did not want the nurse to help the CNA and wanted the CNA to do it alone. The Progress Note revealed, when the nurse started to assist, Resident #3 swore at the staff and began to hit, scratch, punch, and pinch the nurse. (continued on next page)

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

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	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Brookfield	18740 W Bluemound Rd Brookfield, WI 53045

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's Progress Notes, dated 05/02/2025 at 12:00 PM, revealed Resident #3 reported to administration and the Social Service Director that the nurse pushed too hard on their stomach, they reacted and scratched the nurse. Resident #3's Progress Notes, dated 05/16/2025 at 9:28 AM, revealed Resident #3 stated they wanted to speak to the head person in charge and accused staff of hitting them. The Progress Notes indicated the nurse exited the room and called Resident #3's Power of Attorney (POA) to notify them of the resident's refusal to get up for dialysis. The Progress Notes indicated during the telephone call the POA stated a family member watched the cameras and observed someone hit Resident #3 on the head. The Progress Notes indicated management was called immediately. An untitled, undated facility document titled Initial Report on 05/16/2025 at approximately 10:54 AM, Resident #3's POA reported to the Administrator that, at approximately 9:08 AM, CNA A hit Resident #3 in the head while cleaning the resident. The section titled, Investigation revealed Resident #3 told police that a staff member hit them in the head while getting them ready on 05/16/2025, and the resident also referred to an incident that occurred on 05/02/2025, in which they alleged Licensed Practical Nurse (LPN) B punched them in the stomach. The Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, revealed an allegation of staff-to-resident abuse that occurred on 05/16/2025 at 9:08 AM, was discovered on 05/16/2025, and submitted on 05/16/2025 at 1:27 PM. The report indicated CNA A hit Resident #3 in the head during care. During an interview on 06/10/2025 at 1:06 PM, the Administrator stated she spoke with Resident #3 about the incident on 05/16/2025, and the resident stated LPN B pushed on their stomach during care, it was not intentional, and LPN B did not mean to hurt them. During a follow-up interview on 06/10/2025 at 6:11 PM, the Administrator stated she called Resident #3's POA on 05/16/2025 around 10:50 AM, and the POA stated CNA A hit Resident #3. The Administrator stated the report was submitted when she had more details, so it was late.