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	01/08/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to answer a call light and respond for one (Resident (R) 8's) request for assistance in a timely manner out of a sample of 16 residents. This failure caused a delay in meeting the resident's care needs.Findings include:Review of R8's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] and had diagnoses including reduced mobility and muscle weakness.Review of R8's Care Plan Report located in the Care Plan tab of the EMR revealed a fall intervention, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, revised 08/01/25. In addition, the care plan contained an intervention, revised 12/04/24, for assist of one staff with toileting.Review of R8's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/16/25 and located in the MDS table of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition.During an observation on 01/05/26 at 12:51 PM, R8's call light was observed to be on, indicated by a light above her doorway in the hall.During an interview on 01/05/26 from 12:53 PM to 1:32 PM, R8 laid in her bed in her room, call button near her left hand. R8 reported pushing the call button a while ago because she needed staff to assist her in using the bed pan. R8 felt she may have soiled herself because she had diarrhea, and her bottom was sore. R8 stated she started asking for help around 11:00 AM, and she knew her Certified Nursing Assistant (CNA) was busy because the CNA told her she was serving dinner earlier and then she was assisting residents going to dialysis. During the interview she stated she waited an hour at times for her call light to be answered. When asked how often this happened, she said almost daily. She denied having any adverse effects from waiting.During the interview with R8, a dietary aide came in at 1:15 PM to gather R8's lunch tray without asking if R8 needed anything. At 1:28 PM the Housekeeping Supervisor came into the room to remove garbage without asking R8 why her call light was on.During an observation on 01/05/26 at 1:32 PM, Housekeeper (HSKP) 1 entered R8's room. The call light remained on, with the indicator lit above her door. When HSKP1 left the room at 1:38 PM, she walked across the hall to another resident's room and asked CNA7 if she was R8's nurse. CNA7 responded that she was R8's aide and that she told R8 she would be with her, but she had dialysis people she had to take care of first.During an observation on 01/05/26 at 1:48 PM, 57 minutes after the call light was first observed on, the Assistant Director of Nursing (ADON) went into R8's room, asked R8 what she needed, and turned off the call light. The ADON assisted R8 with the bed pan. R8 was observed to have not been incontinent and was without any skin breakdown.During an interview on 01/05/26 at 1:55 PM, the ADON reported staff were expected to respond to call lights timely and not turn them off until the resident received assistance. Fifty-seven minutes to respond to a resident's needs was unacceptable. When an assigned CNA was busy, other nursing staff were to assist as able.During an interview on 01/07/26 at 12:12 PM, CNA7 (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported R8 used her call light to ask for assistance, usually when she needed the bed pan or wanted something from her refrigerator. CNA7 stated R8 was aware that she had to get another resident ready for dialysis on 01/05/26 before she could assist her. Other staff usually answered call lights unless they were really busy.During an interview on 01/08/26 at 11:57 AM, the Director of Nursing (DON) reported the expectation that call lights were responded to within 15 minutes, maybe 20 minutes.Review of the facility's procedure titled, Call Lights, revised 04/08/25, revealed, Respond to resident's call lights in a timely manner . If unable to complete the request, inform the resident/family and notify the appropriate discipline. If this is the case, call light must remain on until the request has been completed.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to ensure the call button to activate the call light system was accessible for two (Resident (R) 11 and 6) of 16 residents in the sample. This failure placed the residents at risk for accident, injury, or unmet needs related to an inability to call for staff assistance.Findings include:1. Review of R11's admission Record located in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] and had diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left non-dominant side.Review of R8's Care Plan Report located in the Care Plan tab of the EMR revealed a fall intervention, Be sure my call light is within reach and encourage me to use it for assistance as needed, revised 08/01/25.Review of R8's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/23/25 and located in the MDS table of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderate cognitive impairment.During an observation on 01/07/26 at 9:14 AM, staff exited R11's room, where he sat up in bed, after setting up his breakfast tray. R11's call button was observed hanging over the edge of the upper left corner of the bedframe, below mattress level, out of reach of the resident.During an observation and interview on 01/07/26 at 10:17 AM, the call button was in the same position, hanging off the upper left corner of the bedframe. R11's breakfast tray was no longer in his room. He reported he was unaware of where his call button was. He stated staff were better recently about clipping it to the blanket, but it might have moved when they sat him up for breakfast.During an interview and observation on 01/07/26 at 10:22 AM, Certified Nursing Assistant (CNA) 4 reported R11 was not assigned to her but confirmed his call button was out of reach, moved it to R11's tray table, and told R11 where it was.During an interview on 01/08/26 at 11:57 AM, the Director of Nursing (DON) reported that she expected staff to clip the call lights, typically to a sheet, within reach of the residents so that residents could not inadvertently knock them off the bed.2. Review of R15's Profile provided by the facility, revealed R15 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.Review of Quarterly MDS with an ARD of 11/17/25 revealed R15 required total assistance with most activities of daily living (ADLs), and extensive assistance of two persons for bed mobility and transfer. R15 also needed physical assist for toileting.During an observation on 01/05/26 at 1:00 PM, R15 was observed in bed talking on her cell phone. The call light was buried under some linen on a chair out of R15's reach. R15 stated she needed to be changed but had no way to call for help. R15 stated this happened quite often and she would call the main facility line, ask for the nursing supervisor, and tell the supervisor she needed to be changed. R15 stated she had made the call about 15 minutes prior.On 01/05/26 at 1:45 PM, when asked, R15 stated no one had come in to assist her yet.On 01/05/26 at 1:46 PM, surveyor informed CNA3 that R15 needed assistance and had been waiting for over 45 minutes. CNA3 stated she did not know that because R15's call light was not on. CNA3 went into R15's room. Surveyor asked CNA3 where R15's call light was. CNA3 confirmed that the call light was not within reach and was in a chair far out of R15's reach and could not be used by R15.During an interview on 01/07/26 at 2:04 PM, the Administrator stated it was her expectation that call lights should be within residents' reach at all times.Review of the facility's procedure titled, Call Lights, revised 04/08/25, revealed, When leaving room, be sure the call light is placed within the resident's reach. Residents that have been identified to move the call light to locations not easily accessible after staff have placed it in a location within reach, should have this behavior included in the resident's plan of care and (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Kardex. Monitor the call light location during rounds to ensure it is within reach of the resident.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to protect one out of one resident (Resident (R)2 from misappropriation of property when Licensed Practical Nurse (LPN) 7 took R2 AirPods without R2's permission. Findings include: Review of the admission Record found under the Profile tab of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, spastic hemiplegia affecting left dominant side, and type 2 diabetes mellitus. Review of the resident's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/25 found under the MDS tab revealed R 2 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. Review of facility's self-reported incident to the state survey agency originally, dated 10/31/25, revealed R2 reported missing AirPods, believed to be left in her room before hospitalization. Facility staff tracked the AirPods via R2's iPhone link. On 11/04/25, the AirPods were found with a LPN7 who was employed at the facility at the time. The AirPods were returned to R2. LPN7 was terminated by the facility after their investigation. During an interview on 01/05/26 at 3:45 PM, R2 revealed her AirPods went missing, and the facility found the nurse that took them, and returned them. During an interview on 01/08/26 at 4:00 PM, the Administrator was informed that since the facility substantiated the allegation of misappropriation by their staff, the facility was responsible for their employees' actions. Review of the facility's policy titled Review of the policy titled Abuse Prevention Program Facility Procedures revealed: Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent . Additionally, misappropriation of a resident's property means obtaining properly of a client by intentionally deceiving the client with a false representation which is known to be false, made with the intent to defraud, and which does defraud he person to whom it is made and/or intentionally using or attempting to use personal identifying information .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to ensure treatments to surgical wounds were documented as completed and were did not ensure that wound treatment was completed when the wound nurse was unavailable for two (Resident (R) 1 and R8) of three residents reviewed for non-pressure skin wounds. This failure had the potential to cause confusion over whether treatments were completed and to cause wounds to decline.Findings include:1. Review of R1's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] and had diagnoses which included displaced comminuted fracture of the shaft of right femur (broken right thigh bone).Review of R1's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/04/25 and located in the MDS table of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. R1 had a surgical wound which required wound care.Review of an Order Audit Report located in the Orders tab of the EMR revealed orders: Wound care for distal end of right hip incision [right knee], and right shin. Cleanse with normal saline, apply collagen sheet and xeroform, cover with ABD [type of dressing] and Kerlix [gauze wrap] daily and PRN, ordered from 12/11/25 to 01/06/26.Review of R1's Care Plan Report located in the Care Plan tab of the EMR revealed a focus area, Risk for Impaired Skin Integrity . Non-pressure wound right shin, Non-pressure wound right knee . revised 12/23/25. Interventions included, Provide skin care per facility guideline and PRN [as needed], dated 05/16/24.Review of R11's Treatment Administration Records (TARs), dated December 2025 and January 2026 and located in the Orders tab of the EMR, revealed the treatment to the right knee and shin was not signed off as completed (remained without documentation) on 12/17/25, 12/22/25, 12/30/25, 12/31/25, 01/01/26, 01/02/26, and 01/06/26.During an interview on 01/07/25 at 9:25 AM, R1 was in bed, covered, and refused interview or wound observation.There was no documentation provided that the treatments were completed on the above dates. 2. Review of R8's admission Record located in the Profile tab of the EMR revealed she was admitted to the facility on [DATE] and had diagnoses including encounter for orthopedic aftercare following surgical amputation and peripheral vascular disease (reduced blood flow to limbs).Review of R8's Care Plan Report located in the Care Plan tab of the EMR revealed a focus area, revised 03/19/25, [Resident] had a [left below the knee amputation] . related to her non-healing wounds . with interventions including: Encourage compliance with treatment regimen.Review of R8's quarterly MDS assessment, with an ARD of 12/16/25 and located in the MDS table of the EMR, revealed a BIMS score of 15 out of 15, which indicated intact cognition. R8 had a surgical wound which required wound care.Review of R8's Order Summary Report located in the Orders tab of the EMR revealed an order dated 12/23/25 for Wound Care for left BKA [below the knee amputation] surgical wound: Cleanse with normal saline; Pack with Dakins soaked gauze then cover . daily and PRN. Another order, dated 11/18/25, indicated Wound Care for right foot surgical site. Wash daily with soap and water . Apply betadine and dry gauze . MWF [Monday, Wednesday, and Friday] and PRN.Review of R8's TARs, dated December 2025 and January 2026 and located in the Orders tab of the EMR, revealed the treatment to the left BKA was not signed off as completed (remained without documentation) on 12/26/25, 12/30/25, 12/31/25, 01/01/26 and 01/03/26. The treatment order for R8's right foot was not signed off as completed (remained without documentation) on 12/17/25, 12/19/25, 12/22/25, 12/26/25, and 12/31/25.During an observation and interview on 01/05/26 at 12:53 PM, R8 reported her wound care was completed every day to her left leg and every other day to her right foot. The treatments were completed as ordered; if missed, it was infrequent. Both dressings were dated, indicating the treatments were completed earlier in the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift.During an interview on 01/06/26 at 1:44 PM, the Wound Treatment Nurse (WCN) 2 reported she did the facility's wound treatments Monday through Friday with other wound care nurses completing treatments on the weekends. If WCN2 was sick or not working, another nurse filled in, or the floor nurses completed their own treatments.During an interview on 01/07/26 at 12:55 PM, Licensed Practical Nurse (LPN) 2 reported she never signed off wound treatments on the TAR because the wound nurses completed them. The facility sent text notifications to the floor nurses if they needed to complete their own wound treatments. LPN2 had not received any text messages regarding wound care in the last month. LPN2 worked on 01/01/26.During an interview on 01/08/26 at 9:52 AM, LPN5 stated the facility texted the floor nurses when they needed to do wound treatments. She worked 01/01/26 but had not received a text to do wound treatments for at least three weeks, to include 01/01/26.During an interview on 01/08/26 at 11:45 AM, WCN2 reported she was sick on 01/01/26 but otherwise did all the facility's wound treatments from Monday through Friday for the last month. When she was sick, the facility sent out a text message for the floor nurses to complete the treatments. WCN2 was unsure who notified the nurses of the need to do treatments on 01/01/26. WCN2 stated she routinely completed all the treatments; however, she was bad with documenting the treatments on the TAR.During an interview on 01/08/26 at 11:57 AM, the Director of Nursing (DON) stated, in general, that wound care was not completed if it was not documented. The DON expected wound care to be documented as completed. If a wound care nurse was unavailable to do treatments, the floor nurses were expected to do the treatments.Review of the facility's policy titled, Documentation Expectations, dated 07/29/25, revealed, It is the policy of this facility that employees will adhere to current standards of practice when documenting on legal documents up to and including resident medical records. Documentation shall be: a. Timely . Document actual events . Documentation is by exception but is expected regarding the following situations: . Treatments.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to ensure treatments to pressure injuries were documented when completed and were completed when a wound treatment nurse was unavailable for two (Resident (R) 1 and R14) of four residents reviewed for pressure ulcers. This failure had the potential to cause confusion over whether pressure injury treatments were completed and to cause wounds to decline.Findings include:1. Review of R1's admission Record located in the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] and had diagnoses which included diabetes and peripheral vascular disease.Review of R1's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/04/25 and located in the MDS table of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. R1 had a stage three pressure injury which received pressure injury treatment.Review of an Order Audit Report located in the Orders tab of the EMR revealed orders: Wound care for left 2nd toe: Cleanse with normal saline, apply Silver Sulfadiazine 1% and calcium alginate . Daily and PRN [as needed] from 12/11/25 to 01/07/26.Review of R1's Care Plan Report located in the Care Plan tab of the EMR revealed a focus area, Risk for Impaired Skin Integrity . Stage 3 PU [pressure ulcer] left 2nd toe . revised 12/23/25. Interventions included, Provide skin care per facility guideline and PRN [as needed], dated 05/16/24.Review of R11's Treatment Administration Records (TARs), dated December 2025 and January 2026 and located in the Orders tab of the EMR, revealed the treatment to the left second toe was not signed off as completed (remained without documentation) on 12/17/25, 12/22/25, 12/30/25, 12/31/25, 01/01/26, and 01/02/26.During an interview on 01/05/26 at 2:05 PM, the Wound Care Doctor (MD) 1 stated that he had not yet made wound rounds on R1 for that day's visit. R1 tends to hit her legs and feet and cause micro trauma. She doesn't even realize she's hitting stuff. [R1's] toe wound had reopened, but it sounds like it may be healed now.During an interview on 01/07/25 at 9:25 AM, R1 was in bed, covered, and refused interview or wound observation.There was no documentation provided that the treatments were completed on the above dates. 2. Review of R14's admission Record located in the Profile tab of the EMR revealed he was admitted to the facility on [DATE] and was re-admitted on [DATE] following a hospital stay which began on 12/26/25. R14 had diagnoses which included osteomyelitis and diabetes.Review of R14's admission MDS assessment, with an ARD of 11/26/25 and located in the MDS table of the EMR, revealed R14 was severely impaired according to the Staff Assessment for Mental Status. R14 was admitted to the facility with a stage two pressure ulcer which received treatment.Review of R14's Order Summary Report located in the Orders tab of the EMR revealed an order dated 12/10/25 for Wound Care for pressure injury to sacrum: Cleanse with normal saline; Apply Silver sulfadiazine 1% and calcium alginate . daily and PRN.Review of R14's Care Plan Report located in the Care Plan tab of the EMR revealed a focus area, revised 12/16/25, The resident has unstageable to sacrum. An intervention, dated 12/03/25, was to Administer treatments as ordered and monitor for effectiveness.Review of R14's TARs, dated December 2025 and January 2026 and located in the Orders tab of the EMR, revealed the treatment to the sacrum was not signed off as completed (remained without documentation) on 12/17/25, 12/18/25, 12/22/25, 12/30/25, 12/31/25, 01/01/26 and 01/02/26.During an observation and interview on 01/05/26 at 2:05 PM, the MD1 assessed and treated R14's sacral wound. MD1 reported the wound had improved from the last weekly visit.During an interview on 01/06/26 at 1:44 PM, the Wound Treatment Nurse (WCN) 2 reported she did the facility's wound treatments Monday through Friday with other wound care nurses completing treatments on the weekends. If WCN2 was sick or not working, another nurse filled in, or the floor nurses completed their own treatments.During (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 01/07/26 at 12:55 PM, Licensed Practical Nurse (LPN) 2 reported she never signed off wound treatments on the TAR because the wound nurses completed them. The facility sent text notifications to the floor nurses if they needed to complete their own wound treatments. LPN2 had not received any text messages regarding wound care in the last month. LPN2 worked on 01/01/26.During an interview on 01/08/26 at 9:52 AM, LPN5 stated the facility texted the floor nurses when they needed to do wound treatments. She worked 01/01/26 but had not received a text to do wound treatments for at least three weeks, to include 01/01/26.During an interview on 01/08/26 at 11:45 AM, WCN2 reported she was sick on 01/01/26 but otherwise did all the facility's wound treatments from Monday through Friday for the last month. When she was sick, the facility sent out a text message for the floor nurses to complete the treatments. WCN2 was unsure who notified the nurses of the need to do treatments on 01/01/26. WCN2 stated she routinely completed all the treatments; however, she was bad at documenting the treatments on the TAR.During an interview on 01/08/26 at 11:57 AM, the Director of Nursing (DON) stated, in general, that wound care was not completed if it was not documented. The DON expected wound care to be documented as completed. If a wound care nurse was unavailable to do treatments, the floor nurses were expected to do the treatments.Review of the facility's policy titled, Wound Management - Wound Prevention and Treatment, revised 10/11/24, revealed, The facility will ensure that based on the comprehensive assessment of a resident: . A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, . Interventions will be implemented in the resident's care plan to prevent deterioration and promote the pressure ulcer's healing.Review of the facility's policy titled, Documentation Expectations, dated 07/29/25, revealed, It is the policy of this facility that employees will adhere to current standards of practice when documenting on legal documents up to and including resident medical records. Documentation shall be: a. Timely . Document actual events . Documentation is by exception but is expected regarding the following situations: . Treatments.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to report changes in eating and supplement consumption and failed to monitor weights and intakes to ensure interventions were in place for three (Residents (R) 1, R12, and R13) out of five residents reviewed for weight loss. This failure had the potential to result in continued weight loss.Findings include:1. Review of R1's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] and had diagnoses which included diabetes, dysphagia (difficulty swallowing), and moderate protein-calorie malnutrition.Review of R1's Order Summary Report, located in the Orders tab of the EMR, revealed an order for weekly weights four times, and then monthly weights, dated 11/21/24.Review of R1's Care Plan Report located in the Care Plan tab of the EMR revealed a focus area, revised on 09/03/25, Resident with alternation in nutritional status . Interventions included: Resident to be weighed per facility protocol.Review of the Weight Summary, located in the Wts/Vitals tab of the EMR, revealed R1 had an 11.7 percent (%) weight loss from 09/26/25 (160.5 pounds (lbs)) to 10/13/25 (141.8 lbs). No additional weights were documented until 01/02/26, when R1 lost an additional 10.5 lbs and weighed 131.3 pounds.Review of a Nutrition/Dietary Note, dated 10/14/25 and located in the Progress Notes tab of the EMR, revealed, Significant wt [weight] change follow up: Resident triggered for wt loss of -5.0% change [Comparison Weight 9/26/25, 160.5 lbs [pounds], -11/7%, -18.7 lbs] from prior wt, which had shown a gain of 6% [+9 lbs] in August. Wt loss remains unplanned and unfavorable given the magnitude and timeframe . Reweight requested to confirm accuracy and assess for ongoing wt change.Review of R1's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/04/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. R1 was documented as having no, or unknown, weight loss.Review of a Nutrition/Dietary Note, dated 01/05/26 and located in the Progress Notes tab of the EMR, revealed, Resident triggering for wt loss of -10.0% change over 180 day[s] . Etiology of wt loss continues to be multifactorial . Per notes resident continues to state she feels good about herself/her health. Wt loss unplanned/unfavorable given the continuation of loss . Monitor weights per facility protocol . Review of the EMR's Progress Notes tab, Wts/Vitals tab, and Medication Administration Records (MARs) under the Orders tab revealed no documentation that R1 refused weights.During an observation on 01/07/25 at 9:25 AM, R1 was in bed, without a breakfast tray and refused interview.During an interview on 01/07/26 at 2:33 PM, the Registered Dietician (RD) stated that R1 would deem her weight loss as planned and favorable. The RD had reviewed R1's food preferences in detail with R1 and documented them and put interventions in place to prevent further weight loss.2. Review of R12's admission Record located in the Profile tab of the EMR revealed she was admitted to the facility on [DATE] and had diagnoses which included diabetes, morbid (severe) obesity, congestive heart failure (CHF) and glaucoma.Review of R12's Order Summary Report, located in the Orders tab of the EMR, revealed two orders for weekly weights. Weight monitoring for CHF. Notify for weight gain 5 lbs. in one week. One time a day every Tuesday was ordered 11/10/23 and Daily weight before breakfast in the morning every Sunday was ordered 01/07/25.Review of R12's Care Plan Report located in the Care Plan tab of the EMR revealed a focus area, revised on 09/22/25, Resident is at nutritional risk . Hx [history] of wt changes. Interventions included: Monitor and record PO [oral] intake of food . Resident will be weighed as ordered by my physician . R12 had an intervention, Eating: Independent with set-up assist for meals, revised on 02/13/25 under her ADL focus area.Review of the Weight Summary, located in the Wts/Vitals tab of the EMR, revealed R12 had a 8.7 percent weight loss from 10/03/25 (206.8 lbs) (continued on next page)

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	525424	A. Building B. Wing	01/08/2026

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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to 10/26/25 (188.9 lbs). No further weights were documented.Review of a Nutrition/Dietary Note, dated 10/27/25 and located in the Progress Notes tab of the EMR, revealed, Significant wt change . Resident triggered for wt loss of -5.0% change over 30 day[s] [Comparison Weight 9/24/2025, 212 Lbs, -10/8%, -23 Lbs] . Wt loss if accurate is unplanned/unfavorable given the amount in the period of time . Recommend continuing to monitor intakes, wts . Monitor weights per facility protocol.Review of R12's annual MDS assessment, with an ARD of 12/08/25 and located in the MDS tab of the EMR, revealed a BIMS score of 12 out of 15, which indicated moderately impaired cognition. R12 had no current weight and was documented as having no, or unknown, weight loss.Review of the EMR's Progress Notes, Wts/Vitals, and Tasks tabs, as well as the MARs under the Orders tab, revealed no documentation that R12 refused weights or that meal intakes were recorded.During an observation on 01/06/26 from 8:35 AM to 9:10 AM, R12 sat up in bed in her room with a breakfast tray in front of her with her eyes closed.During an observation and interview on 01/06/26 at 9:10 AM, R12 sat up in bed in her room with her breakfast tray in front of her containing two slices of toast, one slice mostly eaten, and two uneaten hard-boiled eggs. R12 reported she did not need assistance eating but could barely see her tray. R12 reported she had lost a lot of weight and did not always like the food. She reported the facility gave her a supplemental drink and weighed her with the Hoyer (mechanical) lift.During an observation on 01/07/26 at 9:05 AM, R12 was asleep in bed with her breakfast tray untouched in front of her.During an observation and interview on 01/07/26 at 9:27 AM, R12 awoke to a knock on the door and her name called out. R12 stated her appetite had not been good and reported she had not eaten anything. Two hard-boiled eggs, one piece of toast, and a bowl of bran cereal with raisins were on her tray.During an interview on 01/07/25 at 12:55 PM, Licensed Practical Nurse (LPN) 2 reported R12 had ups and downs with eating and depression. LPN2 stated there was no excuse why R12's weight had not been done.During an interview on 01/07/26 at 2:33 PM, the RD reported she needed to look at her notes regarding R12's weight loss and lack of weights. The RD did not return with additional information.During an interview on 01/07/26 at 4:12 PM, the Assistant Director of Nursing (ADON) stated nursing had just obtained R12's weight. R12 weighed 192.3 pounds, which was an increase of three pounds from her previous weight on 10/26/25.3. Review of R13's admission Record located in the Profile tab of the EMR revealed he was admitted to the facility on [DATE] and had diagnoses which included protein-calorie malnutrition and dysphagia.Review of the Weight Summary, located in the Wts/Vitals tab of the EMR, revealed R13 had a 6.0% percent weight loss from 09/26/25 (161.0 lbs) to 10/14/25 (151.4 lbs). No further weights were documented.Review of R13's Order Summary Report, located in the Orders tab of the EMR, revealed an order, dated 10/14/25, for a general diet with mechanical soft texture and nectar thick liquids per speech language pathologist recommendations based on a swallow study. An order for weekly weights four times followed by monthly weights was ordered on 09/08/25.Review of a Nutrition/Dietary Note, dated 10/17/25 and located in the Progress Notes tab of the EMR, revealed, Significant wt [weight] change . Resident is triggering for significant wt loss of -5.0% change [Comparison Weight 9/26/2025, 161.0 Lbs, -6.0%, -9.6 Lbs] . Nursing noted resident is able to feed self but assistance is provided as needed. Supplementation was recently increased to aid in possible wt loss . This is unplanned/unfavorable loss at this time . Recommend increasing Med Pass to TID [three times a day] . Monitor PO [oral] intake: goal 50% of meals . Monitor weights per facility protocol.Review of R13's Care Plan Report located in the Care Plan tab of the EMR revealed a focus area, revised on 10/17/25 that Resident remains at risk for malnutrition . [history] of significant wt change, possible loss. Interventions included: Weigh per facility protocol and Monitor intake and record q [every] meal.Review of an Order Audit Report, located in the Orders tab of the EMR, revealed an order for Med (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pass 2.0 calorie [supplemental drink] three times a day . to aid in wt stability, from 10/17/25 to 12/02/25.Review of an Order Audit Report, located in the Orders tab of the EMR, revealed that Proheal (supplemental drink) was ordered twice daily on 12/02/25 to replace Med Pass which was on backorder.Review of R13's annual MDS assessment, with an ARD of 12/16/25 and located in the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated he was cognitively intact. R13 ate with supervision, had no current weight entered, and was documented as having no, or unknown, weight loss.Review of R13's Medication Administration Record (MAR), dated December 2025 and located under the Orders tab of the EMR, revealed R13 did not consume his Proheal supplement 40 times out of 59 offerings.Review of R13's MAR, dated January 2026 and located under the Orders tab of the EMR, revealed R13 did not consume his Proheal supplement nine times out of 14 offerings.Review of the EMR's Progress Notes, Wts/Vitals, and Tasks tabs, as well as the MARs under the Orders tab, revealed no documentation that R13 refused weights or that meal intakes were recorded. In addition, there was no documentation that the RD or physician were notified of him refusing the Proheal.During an observation and interview on 01/06/26 at 9:24 AM, R13 was in bed with the head of the bed elevated and breakfast tray in front of him containing a covered plate and two full cups of thickened liquids. R13 reported he was unable to see his food because he was legally blind. R13 reached for the tray and stated he was unable to see to remove the lid. When assisted with the lid, the plate contained scrambled eggs and a biscuit and gravy, none of which was eaten. R13 reported he had lost a lot of weight due to no appetite, food not tasting good, and his inability to see. R13 reported he used to weight 165 pounds and up to 175 pounds. R13 reported he had not been weighed and had not refused to be weighed. He stated he was interested to know what he weighed.During observations on 01/07/26 at 9:40 AM, 9:50 AM, 10:00 AM, and 10:14 AM, R13 was in bed with his breakfast tray on the tray table in front of him. R13 was observed not eating, not touching his meal.During an observation and interview on 01/07/26 at 10:20 AM, Dietary Aide (DA) 1 was observed removing breakfast trays from residents' rooms. DA1 reported she did not do anything if a resident had not eaten their meal or had eaten very little, but she would let the nurse know if the nurse asked.During an observation and interview on 01/07/26 at 10:25 AM, DA2 was removing breakfast trays from residents' rooms. DA2 stated he did not record any intakes; he let an aide (Certified Nursing Assistant) know when there were concerns with intakes. DA2 confirmed R13 did not eat anything and stated that R13 told him he was not hungry. DA2 said that R13 not eating or eating very little was normal recently. DA2 had not told anyone because the nursing staff were aware.During an interview on 01/07/26 at 1:14 PM, CNA5 reported R13 was able to feed himself once sat up in bed. CNA5 reported she told the nurse a couple of weeks back that he was not touching his food. He usually liked breakfast but was not eating it. R13 received supplements, and CNA tried to coax him to eat. His weight was obtained using the Hoyer lift each month.During an interview on 01/07/26 at 2:33 PM, the RD said she would have to look up whether she was aware of R13 not eating well or not consuming his supplement. The RD did not return with any information regarding R13.During an interview on 01/07/26 at 2:40 PM, the RD reported she sent emails requesting missed or questionable weights needing re-done to nursing at least weekly. Some residents refused, and staff relayed verbal refusals, which the RD tried to document. The RD stated weights were based on facility protocol, and that nursing could clarify the protocol. When asked how she approached interventions for weight changes without having current weights or recorded intakes, the RD responded, That's a good question.During an interview on 01/07/26 at 3:40 PM, Licensed Practical Nurse (LPN) 3 stated R13 was very particular with his food and refused weights. LPN3 was unsure if the refusals were recorded and stated she needed to check with the Assistant Director of Nursing (ADON). Nurse management usually (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recorded the monthly weights. R13 was upset with his mechanical soft diet.During an interview on 01/07/26 at 4:12 PM, the ADON stated nursing had just tried to weigh R13, and he refused. Weights were to be done on admission and then according to physician orders. The facility had a standing order for four weekly weights and then monthly weights, but that could be changed by the physician. The orders showed up on the MAR for nurses to document. Nurses were to document in the EMR if residents refused to be weighed and then reattempt. The ADON confirmed there was no prior documentation that R1, R12, or R13 had refused weights. The ADON stated intakes were not documented routinely, but a nurse may put a note in. R13 did not see well and had refused eye surgery. The CNAs should help if he was unable to see or do something.During an interview on 01/08/26 at 11:57 AM, the Director of Nursing (DON) reported she expected nursing to weigh residents according to the physician's orders and document any refusals. The DON was new to the facility and was uncertain about the facility's documentation of meal intakes.Review of the facility's policy titled, Nutrition/Hydration Status Maintenance, revised 10/17/25, revealed, . the facility will ensure that each resident: . Is provided assistance with eating and drinking as needed to support adequate intake and maintain dignity and independence. Is monitored routinely for changes in nutritional and hydration status, which interventions revised as needed based on data such as weights, intake records, . Residents will be weighed per facility protocol and as clinically indicated. Weight variances exceeding [more/less] than 5% in 3- days will prompt evaluation and documentation of potential causes and interventions.Review of the facility's policy titled, Weight Management, dated 03/01/21, revealed, . All residents will be weighed every month unless otherwise ordered by the physician or deemed necessary by the dietician or the interdisciplinary team . 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.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure a resident was transported to dialysis for one (Resident (R) 8) of one resident reviewed for dialysis services. This failure caused the resident to miss a dialysis session and had the potential to result in the resident having fluid overload and abnormal lab results.Findings include:Review of R8's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] and had diagnoses including end stage renal disease and dependence on renal dialysis. Review of an Order Audit Report, dated 11/16/24 and located in the Orders tab of the EMR, revealed an order, Hemodialysis for Chronic Renal Failure Frequency: Mon-Wed-Fri [Monday-Wednesday-Friday] every day shift . Resident taken to dialysis . If dialysis is missed for any reason for one day, BMP [basic metabolic panel- monitors kidney function] lab to be drawn for the following day and reported to MD [physician] . Review of R8's Care Plan Report located in the Care Plan tab of the EMR revealed a focus area, revised on 05/14/25, The resident needs dialysis . with interventions including, Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis 3x [three times] a week as scheduled.Review of R8's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/16/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. R8 received dialysis.Review of a Health Status Note, dated 01/05/26 at 11:15 AM, located in the Progress Notes tab of the EMR, revealed that Licensed Practical Nurse (LPN) 1 documented, Resident missed dialysis today due to 3rd shift staffing. Resident has dialysis at 0500 [5:00 AM] and per Diaysis [sic] nurse all chairs completely booked for the day. MD aware, DON [Director of Nursing] aware. Stat [immediate] BMP [lab] ordered.During an interview on 01/05/26 at 12:53 PM, R8 was in bed in her room. R8 reported she was supposed to go to dialysis at 5:00 AM that morning instead of her normal 9:00 AM time because she had an appointment scheduled in the afternoon. The on-site dialysis center was full, so residents needed to be switched around to accommodate the earlier time. The Certified Nursing Assistant (CNA) started getting her ready for dialysis and put her on the bed pan, but then she left the room and did not return. When the day shift staff arrived, they assisted her, but dialysis was unable to accommodate her at the later time, and she was concerned about missing the afternoon appointment.During an interview on 01/07/26 at 12:12 PM, CNA7 stated, Whoever worked the night shift was not on their 'A' game. They got her on the bedpan and didn't come back. I got her calmed down and tried to see if we could get her in a spot later. LPN1 assisted R8 prior to CNA7 arriving. During an interview on 01/07/26 at 3:51 PM, LPN1 reported that R8 was supposed to go to dialysis at 5:00 AM, on the shift before LPN1's shift. When LPN1 arrived, night shift reported they were unable to find a dialysis chair for R8, and she missed her dialysis slot. When LPN1 messaged dialysis, they had no availability for R8's dialysis. LPN1 notified the doctor and ensured labs were ordered and the resident was monitored.During an interview on 01/08/26 at 11:57 AM, the Director of Nursing (DON) stated that a night shift CNA had called her on 01/05/26 about not being able to locate a dialysis chair to take R8 to dialysis in. The DON instructed the CNA to search the facility, the dialysis area, and the room, and to get R8 to dialysis. Review of the facility's policy titled, Dialysis Policy, revised 05/01/25, revealed, The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, record review, and interviews, the facility failed to ensure medications stored in a secure location, and expired medications were discarded appropriately. This had the potential for facility staff to use expired medications and supplies that could potentially not be effective.Findings included:During a review of the facility's crash carts with the Assistant Director of Nursing (ADON) on 01/08/26 at 11:00 AM, the following was observed:On top of the unlocked, unsecured crash cart in 2 South -Three packs of Tiotropium Bromide Monohydrate inhalation powder expiration date 01/2027 labeled with R16's name. One inhaler was used and had a use by expiration of 08/21/25.At the time of the observation, ADON acknowledged the medications should not have been sitting unsecured on the crash cart. The ADON stated there was a medication room for expired medications, and the inhalers should have been placed there for pharmacy to retrieve and dispose.Review of the facility's policy titled Medication Storage in the Facility dated January 2018 revealed, Medications and biologicals are stored safely, securely, and properly, following manufacturer's 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 .All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.