

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 07/22/2026
NAME OF PROVIDER OR SUPPLIER Aria of Brookfield		STREET ADDRESS, CITY, STATE, ZIP CODE 18740 W Bluemound Rd Brookfield, WI 53045	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policies, the facility failed to ensure food was served at a palatable temperature for three residents (Residents (R)16, R27, R28) of three residents reviewed for food palatability. This failure poses the risks of weight loss, reduced quality of life, and foodborne illness for Findings include: 1. Review of R16's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 05/15/26, located in the electronic medical record (EMR) under the MDS tab, revealed an admission date of 03/14/25 and diagnoses of urinary tract infection (UTI), malnutrition, and heart failure. Review of R16's Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, indicating R16's cognition was intact. Review of R16's care plan, revised 05/27/26, located in the EMR under the Care Plan tab revealed Resident is at risk for malnutrition r/t [related to]: a PMHx [past medical history] of hypertension, hypothyroidism, CHF [chronic heart failure], GERD [gastroesophageal reflux disease], and hx [history] multiple PIs [pressure injuries]. Review of R16's order, dated 07/13/26, located in the EMR under the Order tab revealed NAS (No Added Salt) diet, Regular texture, Regular (Thin Liquids) consistency. On 07/20/26 at 11:55 AM, R16 was in bed awake with her Family Member (FM)5 at her bedside. R16 and FM5 stated, the food is cold because the trays come out and sit on the cart too long. On 07/22/26 at 8:35 AM, the breakfast cart on the hall was in progress. At 8:55 AM, R16's breakfast tray was delivered to her room. R16 was served scrambled eggs, pancakes, syrup, oatmeal, and milk. R16 commented that her eggs and pancakes are not warm. R16's plate did not contain an insulated base, just the insulated cover. During an interview on 07/22/26 at 9:06 AM, the Registered Dietitian (RD) stated the kitchen did not have a manager at this time and she was just filling in for the other RD. RD was unaware of who monitored food temperatures for food palatability. 2. Review of R28's significant MDS with an ARD date of 11/11/26, located in the EMR under the MDS (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
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility grievance file, provided by the facility, revealed on 07/06/26 resident reported concerns with temperature of the food. No details were provided of which meal it was or what day. The resolution included the Assist Administrator spoke with resident who stated she did not eat the meal immediately after it was delivered. Review of the Resident Council Minutes, provided by the facility, revealed on 04/05/26 a resident complained about the toast and sometimes it is hard and sometimes soggy. [name] said they are working on getting it right. One resident asked about plate warmers and he said they are looking into that or another solution. On 06/17/26 Residents brought up heated trays and Administration is working on that. Review of the facility policy titled The Dining Experience, undated, provided by the facility, revealed Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional, and/or special dietary needs and food preferences and are served at a safe and appetizing temperature. Review of the facility policy titled Food Temperature, undated, provided by the facility, revealed 1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and review of facility policies, the facility failed to ensure one of one residents (Resident (R) 5) was assessed for self-administration of medication. As a result of this deficient practice the residents had the potential for harm of not receiving physician prescribed medications. Findings include: Review of R5s admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 05/17/24 and readmission on [DATE] with medical diagnoses that included type 2 diabetes and major depressive order. Review of R5's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 05/06/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R5 was cognitively intact. During an observation on 07/20/26 at 1:40 PM, 5 pills and one capsule were noted on a napkin on the lunch tray. R5 stated she was taking them on her own, after lunch. Review of R5's EMR under the Forms tab lacked documentation of an assessment for Self-Administration of Medications. During an interview on 07/20/26 at 1:52 PM, Licensed Practical Nurse (LPN) 9 stated she left the medications in a med cup on the bedside table about 10:00 AM this morning. LPN 9 confirmed that R5 did not have an assessment completed for self-administration of medication and should not have left them with the R5 without confirming administration During an interview on 07/21/26 at 3:10 PM, the Director of Nursing (DON) confirmed an assessment for self-administration of medications had not been completed for R5 and should have been done before medications were left at the bedside. Review of the facility policy titled Self-Administration of Medications, revised 01/2018, revealed If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process. Review of the facility policy titled Medication Administration-General Guidelines, revised 12/19, revealed The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.		

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to properly prepare for the arrival of a resident who had been pre-screened and approved for placement, resulting in a resident being returned to the hospital for one resident (Resident (R)2) of three residents reviewed for admissions. This failure caused a disruption of the resident's continuum of care and could have triggered negative consequences. Findings include: Review of the Email thread from the admission Director (ADD,) revealed on the first thread dated Friday, 06/05/26, provided by the facility, revealed Sunday 6/7 [R2's name], [hospital abbreviations], Time: Leaving at 2pm, Payer: [name of insurance provider], RM [room number], 5'[feet]2[inches], 253 lbs [pounds], Presented for SOB [short of breath] and leg swelling, Full Code, Diet: Cardiac, *2L[liters] 02[oxygen]*, STR [short-term rehabilitation], Own person. Second thread dated Sunday, 06/7/26 at 1:51 PM, revealed admission announcement Sunday 6/7 &ndash; [R2's name] [facility name]. She is coming today at 2pm!!! Review of the hospital records/Referral, dated 06/01/26, provided by the hospital revealed Patient will continue to benefit from skilled therapy while in the hospital to address above impairments and further increase independence with functional mobility to facilitate a safe and appropriate discharge, Placement Needs: SNF [skilled nursing facility]/SAR [subacute rehabilitation], Discharge Location Recommendation: post acute rehab [rehabilitation]. During a telephone interview on 07/21/26 at 4:22 PM, the Facility Liaison (FL) stated the reason R2 wasn't admitted to the facility on Sunday 06/07/26 was because it was the Nurse's issue as she didn't know R2 was being admitted . The FL stated everyone was supposed to be aware as he sent an email admission announcement. During an interview on 07/21/26 at 4:58 PM, the Regional Director of Operations (RDO) stated, Yes, the facility knew R2 was supposed to be admitted on [DATE] at 2:00 PM. The RDO stated Licensed Practical Nurse (LPN)10 didn't think they took weekend admissions. The RDO stated, the admitting nurses were not on the email that announced admissions, the admitting nurse received word by the management staff. During a telephone interview on 07/21/26 at 6:56 PM, LPN10 stated it was a Sunday and she saw the ambulance at the end of unit and she had no idea there was an admission. LPN10 stated she was told R2 was admitted but she had no report from the hospital. LPN10 stated, Normally the hospital nurse calls them, but she didn't receive a call. LPN10 stated R2's room wasn't ready, as the floor was dirty and the bed wasn't made. LPN10 stated she had not looked at R2's medications and so she told R2's son she had not received report for R2. LPN10 informed the ambulance personnel and R2's son she could not accept R2. R2 was still on the stretcher and the ambulance personnel returned R2 to the (continued on next page)		

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital. LPN10 stated she is made aware of admissions by the hospital's customer relations person [name] who will text, call, or tell them in person about new admissions, but LPN10 stated she did not get that. LPN10 stated normally they don't have admissions on weekends. LPN10 stated the Hospital's Case Manager, called the facility, and told the receptionist they were getting an admission. LPN10 stated the Case Manager said, you guys are accepting this admission, but the receptionist did not tell her. When LPN10 talked to the Case Manager, she kept saying Name of a person said R2 can come but LPN didn't know of anyone that worked at the facility by that name. LPN10 went on to say later she found out it was the admission Director (ADD), who was one of the admissions persons. During a telephone interview on 07/22/26 at 11:24 AM, ADD stated R2 was accepted as an admission to their facility and R2 was supposed to be admitted on a Sunday, 06/07/26 for shortness of breath and leg swelling. The ADD stated, We could have cared for her. ADD stated she told the hospital social worker about R2's weekend admissions. An email was sent on Friday, 06/05/26 and a follow up email on Sunday, 06/07/26. ADD stated all management were informed via the same email that was sent to the hospital SSW. ADD stated the facility's nurse manager, or the nurse-on-call should have informed the facility's admitting nurse. Review of the facility policy titled Admission/readmission Procedure, revised 11/10/25, provided by the facility revealed Pre-admission: . 5. Room readiness completed by IDT [interdisciplinary team]. 6. admission notifications sent to nursing staff and leadership prior to admission. Notifications include, isolation needs, special equipment needs, following physician, admitting location, discharge summaries and orders needed. Process: 1. The receiving unit is notified by the admissions office as soon as possible regarding the upcoming admission. 2. A qualified staff member conducts the admission process involving the resident and family. 7. Information about resident admission is communicated in a timely manner to the appropriate departments. Procedure: 1. The admission office, nursing department, guest relations, and housekeeping make preparation before the arrival of a new patient. 2. The admissions office obtains information regarding the resident and forwards that to the appropriate nursing personnel for report.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policies, the facility failed to provide the resident and/or representative with written transfer and bed-hold notices that included where and why the resident was transferred for three residents (Resident (R6), R16, R3) of three residents reviewed for hospitalization. The failure had the potential to affect the residents and/or their representative concerning the residents' appeal rights. Findings include: 1. Review of R6's admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 08/30/24 and readmission on [DATE] with medical diagnoses that included end-stage renal failure. Review of R6's Prog Notes tab in the EMR dated 05/13/26 at 6:18 PM, revealed R6 was admitted to the hospital due to gastrointestinal (GI) bleed. Review of R6's Prog Notes tab in the EMR dated 05/14/26 at 9:51 AM, revealed SW (Social Worker) left resident a voicemail in regard to a behold due to resident being in the hospital. During a phone interview on 07/20/26 at 12:08 AM with Family Member (FM) 1, she stated no paperwork was received when transferred to the hospital in May. Review of R6's Misc tab in the EMR revealed the document titled Healthcare Bed Hold Notice dated 05/14/26, the signature line written verbal consent; R6 [name], and the document titled Notice of Transfer dated 05/14/26 with the reason for notice of transfer documented hospitalization. 2. Review of R16's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 05/15/26, located in the EMR under the MDS tab, revealed an admission date of 03/14/25 and diagnoses including urinary tract infection (UTI), malnutrition, and heart failure. Review of R16's Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, indicating R16's cognition was intact. Review of R16's Health Status Note, dated 07/10/26, located in the EMR under the Progress Note, revealed Writer was alerted by CNA [Certified Nurse Aide] that resident had 3x [three times] emesis last night and that she wasn't looking good. Writer went in and obtained vital signs, temp [temperature]102. Writer updated MD [physician] and stated that the resident wanted to go out to the hospital, MD agreed. Resident was sent to Waukesha memorial hospital. ADON [Assistant Director of Nursing] was also notified. Review of R16's NRSG [nursing]: admission Data Collection Progress Notes, dated 07/13/26, located in the EMR under the Progress Note, revealed Resident arrived via ambulance to facility after hospitalization following UTI [Urinary Tract infection]. Resident with history of multidrug resistant (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	UTI. Resident was treated to meropenem in the hospital and transitioned to oral antibiotics prior to discharge and readmission to facility. Review of R16's Bed-Hold and Transfer Notices, dated 07/13/26, located in the EMR under the Miscellaneous tab revealed the notices provided verbally and not written. The Notice of Transfer did not include the reason R16 was being transferred or the location in which R16 was being transferred to. During an interview on 07/22/26 at 9:33 AM, the Administrator confirmed R16 was sent to the hospital 07/10/26The Administrator wasn't aware R16 nor Family Member (FM) 5 did not receive a written copy of the bed-hold notice or the transfer notice. She stated she thought R16 did receive a written copy. During an interview on 07/22/26 at 10:45 AM, the Administrator confirmed the location and reason for the transfer was not on R16's transfer notice. During a follow-up interview on 07/22/26 at 12:30 PM, the Administrator confirmed the 07/13/26 notices for bed-hold and transfers were documented as verbal. The Administrator stated the notices are sent with the ambulance along with the other transfer information for the hospital staff to give to R16 and FM5. The Administrator stated she could not prove the notices were provided in writing. 3. Review of R3's non-federal MDS with an ARD date of 03/10/26, located in the EMR under the MDS tab, revealed an admission date of 03/03/26, received hemodialysis and diagnoses including displaced fracture of base of neck of left femur, subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus with diabetic chronic kidney disease, and hypotension of hemodialysis. Review of R3's Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, indicating R3's cognition was intact. Review of R3's Health Status Note, dated 03/11/26 at 16:47, located in the EMR under the Progress Note, tab revealed Resident admitted at [name] Hospital for Hypoglycemia, acute encephalopathy, increased troponin and syncope. Review of R3's Bed-Hold and Transfer Notices, dated 03/11/26, located in the EMR under the Miscellaneous tab revealed the notices were provided verbally and not written. The Notice of Transfer included a handwritten note hospitalization but did not include the reason for the hospitalization or the location in which R3 was being transferred. During an interview on 07/21/26 at 4:00 PM, the Administrator stated R3's representative could not come to the facility and that was why the representative was telephoned. The Administrator stated the social worker sent the notices in the mail but there was no documentation to prove it. During an interview on 07/22/26 at 9:30 AM, the Administrator stated the facility does not have a process to confirm that the notices are mailed and they have no way to prove it. The Administrator stated they send the notices with the residents via EMS but again there was no way to confirm whether the hospital staff are giving it to the residents or their representative. The Administrator (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review the facility failed to ensure physician narcotic orders were accurately transcribed to the Medication Administration Record (MAR) in the electronic medical record (EMR) for 2 of 5 residents (Resident (R) 5 and R7). As a result of this deficient practice, residents have the potential for both over medication and under medication. Findings include: 1. Review of R5s admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 05/17/24 and readmission on [DATE] with medical diagnoses that included type II diabetes and major depressive disorder. Review of R5's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 05/06/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R5 was cognitively intact. Review of R5's Prog Note tab in the EMR revealed on 04/08/26 at 13:06 PM, revealed an interdisciplinary team (IDT) meeting was convened to review and address a medication discrepancy involving Suboxone for resident R5. However, the facility failed to investigate. Review of R5's MAR in the EMR for December 2025, revealed the following orders: Buprenorphine HCl-Naloxone HCl Sublingual Film 4-1 milligram (mg). [Suboxone] Give 1 film sublingually in the morning for opioid use / pain -Start Date- 07/17/2025 and a second order on the December MAR documented Buprenorphine HCl-Naloxone HCl Sublingual Film 2-0.5 mg [Suboxone] Give 1 film sublingually one time a day for opioid dependence -Start Date- 12/18/2025. Review of R5's narcotic sign out sheets, provided by the facility, for December 2025 to March 2026 revealed Drug Bupren/Nalox [Suboxone] 4-1mg sublingual film. 1 film inside the cheek once daily, Summary: Suboxone 4mg sublingual once a day. Review of R5's MAR from January 2026 to March 2026 revealed the physician's order Buprenorphine HCl-Naloxone HCl Sublingual Film 2-0.5 mg. Give 1 film sublingually one time a day for opioid dependence -Start Date- 12/18/2025 -D/C Date- 04/08/2026. Summary: Suboxone 2mg sublingual once a day. Review of R5's MAR for April 2026, revealed a physician's order for Buprenorphine HCl-Naloxone HCl Sublingual Film 2-0.5 mg [Suboxone]. Give 1 film sublingually one time a day for opioid dependence -Start Date- 12/18/2025. 04/01/26 and 04/02/26 doses were documented as not administered. During an interview on 07/22/26 at 11:26 the Director of Nursing (DON) confirmed the medication for R5 ran out at the end of March 2026 and R5 went two days without the Suboxone and the Nurse Practitioner (NP) was asked to write the renewal since the renewal process had not been initiated timely. The NP used the MAR information prescribed the Suboxone 0.2mg sublingual once a day. The DON stated R5 then received Suboxone 0.2mg dosing for the next six days as documented on the MAR. R5 complained about the dose not being correct, the facility then identified the issue since 12/17/25 which the MAR documented Suboxone 2mg and the narcotic sign out sheet documented Suboxone 4mg. Also, the refill order from the NP was for Suboxone 2mg and the dose R5 had been receiving was 4mg. During an interview on 07/22/26 at 11:15 AM, the Staff Development/Infection Preventionist explained in December 2025, the Pharmacist recommended a gradual dose reduction (GDR) for R5 Suboxone from 4mg to 2mg. The pharmacy recommendation was not approved by the physician and the previous DON decided to reduce the dose and put the order into the EMR for Suboxone 2mg. However, the narcotic prescription from the physician was never changed from Suboxone 4mg. Review of R5's EMR lacked documentation of the pharmacy recommendation for December 2025. During an interview on 07/22/26 at 12:25 PM. LPN8 confirmed working at the facility for four years on the same unit as R5 and was unaware there was an (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	error with the Suboxone for over three months. LPN8 explained that the pharmacy would call if there was a discrepancy between the physician orders and the MAR and depended on the pharmacy for any discrepancies. During an interview on 07/22/26 at 11:16 AM the DON and the Regional Director of Operations (RDO) confirmed the medication error identified 04/08/26 involving R5 was not fully investigated by the facility resulting in staff over the first four months of the year were not checking the narcotic being administered with the physician order documented in the MAR. 2. Review of R7's admission Record located in the EMR under the Profile tab, revealed an admission date of 06/25/26 with medical diagnoses that included right leg below the knee amputation and left foot amputation. Review of R7's admission MDS located in the EMR under the MDS tab with an ARD of 07/02/26, revealed a BIMS score of 14 out of 15, indicating R7 was cognitively intact. During an observation on 07/20/26 at 2:09 PM, R7 was noted in her room alert, oriented, and moving around in bed. Review of R7's MAR for July 2026 documented a physician's order dated 07/09/26 for Oxycontin Oral Tablet extended release (ER) 12-hour Abuse Deterrent 10 mg (Oxycodone HCL). Give 10 mg by mouth three times a day for pain. Review of R7's narcotic sign out sheet, provided by the facility, for Oxycodone 10mg documented the prescription Oxycodone 10mg one tablet twice a day. Review R7's Misc tab in the EMR handwritten physician's order dated 07/09/26 revealed Oxycodone 10mg twice a day (BID). The handwritten order had no date or time, the person noting the order was initialed as noted and lacked a date and time the order was noted. Review R7's Misc tab in the EMR two other narcotic orders, for Percocet and Tramadol were handwritten by the physician, lacked dates and times, and lacked a notation that the order had been noted. During an interview on 07/20/26 at 4:00 PM, the DON reviewed the order on the MAR and confirmed the handwritten order was incorrectly transcribed resulting in R7 receiving three doses of oxycodone during the regularly scheduled times for an administration of three times a day in the morning, afternoon and at night. The DON confirmed these doses were not 12 hours apart. During a phone interview on 07/22/26 at 10:04 AM, the Pharmacist confirmed the process for the facility to obtain the narcotics for the residents involved the prescription being sent from the physician to the pharmacy to fill. They compare the prescription with the narcotic being distributed to the facility as their internal check and do not verify narcotics with the EMR system. The Pharmacist also explained that the 12 ER oxycodone has properties to prevent a potential overdose of oxycodone for R7 as well as her long history of narcotic use and high tolerance. Review of the facility policy titled Controlled Substance Prescriptions, reviewed 01/2018, revealed Documentation of the Controlled Substance Prescription. 1) Each controlled substance prescription is documented in the resident's medical record with the date, time, and signature of the person receiving the prescription. The prescription is recorded on (the physician order sheet . or the telephone order sheet . or posted elsewhere in the record, and recorded on the Medication Administration Record (MAR)/electronic medical record . 2) New orders for controlled substances communicated to the nurse verbally or orally by the prescriber via telephone were entered onto the [physician order sheet telephone order sheet/electronic medical record] and noted as follows: [T.O., noted 3:00 p.m.5/1712011, M. [NAME], R.N.] or as determined by an electronic health record system. Review of the facility policy titled Medication Administration-General Guidelines, revised 12/2019, revealed Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and review of facility policies, the facility failed to ensure nurses who administered a narcotic, confirmed the dosage administered matched the prescription order on the narcotic sign out sheet and the physician's order on the Medication Administration Record (MAR), for one of four residents (Resident (R) 7) reviewed for administered narcotics. This deficient practice had the potential for resident overdosing. Findings include: Review of R7's admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 06/25/26 with medical diagnoses that included right leg below the knee amputation and left foot amputation. Review of R7's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 07/02/26, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R5 was cognitively intact. During an observation on 07/20/26 at 2:09 PM, R7 was noted in her room alert, oriented, and moving around in bed. Review of R7's MAR for July 2026 documented a physician's order dated 07/09/26 for Oxycontin Oral Tablet extended release (ER) 12-hour Abuse Deterrent 10 milligram (mg) (Oxycodone HCL). Give 10 mg by mouth three times a day for pain. Times of administration were set for AM, PM, and HS (bedtime) Review of R7's narcotic sign out sheet from the pharmacy, provided by the facility, documented the prescription Oxycodone 10mg one tablet twice a day. The actual times the medication was administered were documented on the narcotic sheet and revealed the following days and times the oxycodone 10mg was administered: 07/12/26 PM dose administered at 6:30 PM, HS dose administered at 9:09 PM, 2 hours 40 min after PM dose was administered 07/13/26 AM dose administered at 7:24AM, PM dose administered at 6:15PM, 11 hours 45 minutes after AM dose, and HS dose administered at 9:38 PM, 3 hours 18 minutes after PM dose was administered. 07/14/26 AM dose not administered, PM dose administered at 7:33PM, and HS dose administered at 9:31PM, 2 hours 1 minute after PM dose was administered. 07/15/26 AM dose administered at 7:35 AM, PM dose administered at 4:46 PM, 9 hours 11 minutes after AM dose, and HS dose administered at 8:56 PM, 4 hours 10 minutes after PM dose was administered. 07/16/26 AM dose administered at 7:34 AM, PM dose administered at 5:07PM, 9 hours 33 minutes (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after AM dose, and HS dose administered at 8:39 PM, 3 hours 28 minutes after PM dose was administered. 6. 07/17/26 AM dose administered at 8:11 AM, PM dose administered at 5:30 PM, 9 hours 19 minutes after AM dose, and HS dose administered at 9:04 PM, 3 hours 34 minutes after PM dose was administered. 7. 07/18/28 AM dose administered at 8:04 AM, PM dose administered at 3:04 PM, 7 hours after AM dose, and HS dose administered at 7:54 PM, 4 hours 50 minutes after PM dose was administered. 8. 07/19/26 AM dose administered at 6:46 AM, PM dose administered at 5:39 PM, 10 hours 8 minutes after AM dose, and HS dose administered at 10:03 PM, 4 hours 24 minutes after PM dose was administered. 9. 07/20/26 AM dose administered at 7:20 AM, PM dose administered at 3:30 PM, 8 hours 45 minutes after AM dose. Review R7's Misc tab in the EMR handwritten physician's order dated 07/09/26 revealed Oxycodone 10mg twice a day (BID). The handwritten order had no date or time, the person noting the order was initialed as noted and lacked a date and time the order was noted. During an interview on 07/20/26 at 4:00 PM, the Director of Nursing (DON) was informed about the concerns with the oxycodone 10mg order being administered three times a day when the order was for two times a day. The DON confirmed the order in the EMR was not correctly transcribed and the order was for two times a day (BID) not three times a day (TID), which was what was entered into the EMR. The DON verbalized the need to change the order in the EMR, so doses were given based on a correct order going forward. The DON confirmed these doses were not 12 hours apart and should have been. Review of R7's narcotic sign out record for 07/20/26 revealed the HS dose of oxycodone 10 mg was administered at 7:35 PM, 4 hours and 4 minutes after the PM dose was administered. During an interview on 07/21/26 at 1:49 PM, the DON and the Administrator explained the actions taken following the information about the oxycodone 10mg order being entered into the EMR system incorrectly. They stated the physician was called, but the notification was not documented in the progress notes, and the DON confirmed not changing the order on 07/20/26 after the 4:00 PM interview. This resulted in R7 in receiving the HS dose of oxycodone 10 mg at 7:35 PM, 4 hours and 4 minutes after the PM dose was administered. During a phone interview on 07/22/26 at 10:04 AM, the Pharmacist confirmed the process for the facility to obtain the narcotics for the residents involved the prescription being sent from the physician to the pharmacy to fill. They compare the prescription with the narcotic being distributed to the facility as their internal check and do not verify narcotics with the EMR system. Review of the facility policy titled Controlled Substance Prescriptions, reviewed 01/2018, revealed (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation of the Controlled Substance Prescription. 1) Each controlled substance prescription is documented in the resident's medical record with the date, time, and signature of the person receiving the prescription. The prescription is recorded on (the physician order sheet . or the telephone order sheet . or posted elsewhere in the record, and recorded on the Medication Administration Record (MAR)/electronic medical record . 2) New orders for controlled substances communicated to the nurse verbally or orally by the prescriber via telephone were entered onto the [physician order sheet telephone order sheet/electronic medical record] and noted as follows: [T.O., noted 3:00 p.m.5/1712011, M. [NAME], R.N.] or as determined by an electronic health record system. Review of the facility policy titled Medication Administration-General Guidelines, revised 12/2019, revealed Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to appropriately pre-screen a resident before admission to determine whether the facility could meet the resident's needs and subsequently discharged the resident, because they were unable to provide the required care for one resident (Resident (R1) of one resident reviewed for the Facility Assessment. This failure had the potential to result in undue hardship for residents and disrupt the continuity of care. Findings include: Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 02/24/26, located in the electronic medical record (EMR) under the MDS tab, revealed an admission date of 02/24/26 and diagnoses including cerebral infarction due to thrombosis of precerebral arteries, hemiplegia following a cerebral infarction on the right dominant side, and encephalitis and encephalomyelitis, unspecified and had a feeding tube. Review of R1's Brief Interview for Mental Status (BIMS) revealed a score of 99, indicating R1's cognition was severely impaired. Review of R1's referral packet, dated 02/10/26, provided by the facility, revealed Secondary Diagnosis: acute ischemic left MCA [Middle Cerebral Artery] stroke s/p [status post] decompressive hemicraniectomy [an emergency life-saving surgery where a neurosurgeon removes a large flap of the skull, leaving an opening]. Radiology: Soft Tissues and Skull: Left craniectomy noted. Mild left-sided scalp soft tissue swelling noted overlying the craniectomy. No skull fracture. Impression: 1. Status post left craniectomy with chronic-appearing left MCA territory encephalomalacia. There is associated expansion of the left cerebral hemisphere through the craniectomy defect . Review of R1's hospital Discharge summary, dated [DATE], located in the EMR under the Miscellaneous tab revealed Final diagnosis: 1. Acute ischemic MCA stroke, s/p hemicraniectomy. 7. S/p left hemicraniectomy. aspirin 81 MG [milligram] chewable tablet Administer 1 tablet (81 mg total) per tube in the morning. Indications: Stroke Due To Limited Blood Flow, Acute ischemic left MCA stroke status post hemicraniectomy 11/18/25. Review of R1's Health status Note, dated 02/24/26 at 13:47, located in the EMR under the Progress Note, revealed VS [vital signs] rechecked 1 hour post midodrine administration and are as follows: BP [blood pressure] 72/52, HR [heart rate] 106 BPM [beats per minute], Oxygen Sat [saturation]. 95% MD [physician] notified. Review of R1's skin/wound note, dated 02/24/26 at 14:02, located in the EMR under the Progress Note, revealed Writer completed head to toe skin assessment. No skin impairments noted. Healed surgical incision to left head present. Skin is clean, dry and intact upon admission to the facility. Review of R1's Health Status Note, dated 02/24/26 at 14:16, located in the EMR under the Progress (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note, revealed MD stated to send resident out to ER for eval [evaluation] and treat. Review of R1's Hospital Records, dated 02/24/26, provided by the hospital, revealed [DON- Director of Nursing] from [facility name] calling to inform staff that, due to patient's hx [history] of a craniotomy, patient cannot return to facility due to patient acuity. Writer informing DON that patient will be admitted overnight for observation and will inform admission RN of this information. Review of R1's Health Status Note, dated 02/26/26, located in the EMR under the Progress Note, revealed Facility Regional Director of Sales and Marketing spoke with guardian- [name]. Guardian stated resident will not be returning to facility and requested resident's belongings to be brought to hospital. Regional Director packed belongings and brought them to hospital. During a telephone interview on 07/20/26 at 1:28 PM, FM6 stated the facility had admitted R1 and then a few hours later sent R1 to the hospital for a possible fall out of the bed and for being hypotensive. FM6 stated the facility wouldn't readmit R1 because she had a craniotomy but had a helmet. During an interview on 07/21/26 at 10:16 AM, the Administrator stated R1 was sent to hospital due to low blood pressure. The Administrator stated R1 wasn't readmitted because R1 had clinical conditions the family did not tell them about. The Administrator stated therefore, R1 was denied coming back due to safety concerns. During an interview on 07/21/26 at 10:23 AM, the DON stated the family wanted R1 to be physically restrained and that R1 had a history of falls. After reviewing the hospital paperwork, the DON stated she realized R1 had a bone flap and wore a helmet for protection. The DON stated, We don't accept residents with helmets for that purpose. The DON stated the POA [power of attorney] was informed that the facility does not use physical restraints and that R1's bone flap was also a condition for which they could not care. The DON stated the facility recognized it should not have accepted R1. The DON stated, It was in the hospital paperwork, but since the Facility Liaison (FL) isn't clinical, he didn't pick up on it. The DON further stated the FL was onsite at the hospital when screening R1, but R1 was not wearing the helmet, and the FL did not recognize the condition. The DON stated residents with bone flaps or helmets are not accepted due to fall risks and safety concerns. The DON reviewed the Facility Assessment and confirmed it did not identify or indicate if residents who wore helmets were appropriate for the facility. During a telephone interview on 07/21/26 at 4:27 PM, the FL stated he visited R1 at the hospital, spoke with hospital staff, and reviewed R1's paperwork. The FL stated the paperwork did not indicate R1 had a bone flap and he was unaware the facility could not provide care for R1's condition. However, because the condition was not identified during his hospital visit, he accepted R1 for admission. During a telephone interview on 07/22/26 at 11:30 AM, the Admissions Director (ADD) stated R1 was not appropriate for placement at the facility and was denied readmission. The ADD stated she had a referral for R1 but missed the diagnosis and condition. (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility assessment, dated 6/18/26, provided by the facility revealed under Common Diagnoses and Specific Care or Practices, hemicraniectomy was not listed as a condition the facility provided care and services for. Review of the facility's Admissions Education, dated 02/26/26, provided by the facility as the practice used at the time of R1's admission, revealed The purpose of this education is to ensure the Admissions Team completes a thorough, consistent, and clinically sound review of every referral. Each referral must go beyond the admitting diagnosis to identify the underlying cause of the acute hospitalization and confirm that the facility can safely and appropriately meet the prospective resident's needs.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policies, the facility failed to follow Enhanced Barrier Precautions, use proper hand hygiene, and keep soiled linens off the floor for one resident (Resident (R)15) of three residents reviewed for infection control. These breaches in infection control have the potential to cause a spread in disease and affect all the residents. Findings include: Review of R15's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 07/15/26, located in the electronic medical record (EMR) under the MDS tab, revealed an admission date of 07/08/26 and diagnoses including multidrug-resistant organism (MDRO), bacteremia, and cellulitis of right and left lower limbs and wounds. Review of R15's Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, indicating R15's cognition was intact. Review of R15's order, 07/08/26, located in the EMR under the Order tab revealed Isolation: Enhanced Barrier Precautions; Resident is in isolation with Enhanced Barrier Precautions for protection every shift. Review of R15's care plan, dated 07/17/26, located in the EMR under the Care Plan tab revealed The resident requires enhanced barrier precautions related to wounds. An intervention included Implement Enhanced Barrier Precaution. Review of R15's skilled daily note, dated 07/17/26, located in the EMR under the Progress Note tab, revealed Due to recent history of MRSA bacteremia, resident remains under skilled observation for signs and symptoms of recurrent infection. During an observation on 07/20/26 at 10:03 AM, an Enhanced Barrier Precaution (EBP) sign was noted on R15's open door and a bin containing personal protective equipment (PPE) was located outside of R15's door. R15 was in bed, and soiled laundry and bed sheets were noted directly on the floor rather than bagged. Certified Nurse Aide (CNA) 1 was in the room and was wearing gloves but no other PPE. CNA1 gathered the soiled items from the floor and placed them in a hallway bin. CNA1 was unable to provide knowledge of why R15 had an EBP sign on his door. During an observation on 07/20/26 at 10:07 AM, CNA1 was in R15's room wearing only gloves (no other PPE) and positioned the resident's right leg. At 10:08 AM, CNA1 removed her gloves, exited the room, and discarded the gloves in a trash bin. CNA1 entered room [ROOM NUMBER] without performing hand hygiene. During an observation on 07/20/26 at 12:28 PM, R15 was sitting in a wheelchair in his room and lower legs were noted to be very scaly. R15 appeared to be very sleepy. During an interview on 07/20/26 at 2:28 PM, CNA1 confirmed she did not wear a gown when changing R15's brief and bed sheets. CNA1 stated it was acceptable to place soiled linens directly on the floor, (continued on next page)		

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 07/22/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because she would place the linens in the bins. During an interview on 07/22/26 at 9:08 AM, the Infection Preventionist (IP stated, CNAs are to gown-up when they touch bodily fluids, during patient care, including incontinent care and changing bed linens. The IP also stated, soiled sheets are to be placed in a bag and into the receptacles. The IP also stated, Nothing should be on the floor. The IP stated once gloves are removed, CNAs are to perform hand hygiene. The IP confirmed R15 had an EBP sign due to wounds. Review of the facility in-service records, dated 04/15/26, provided by the facility, revealed CNA1 received instructions regarding linen and garbage separation. Review of the facility policy titled Hand Hygiene, revised 04/01/25, provided by the facility revealed 2. Alcohol-based hand sanitizer is appropriate for decontaminating the hands:. d. After contact with a resident; e. When moving from a contaminated body site to a clean body site during resident care; f. After contact with body fluids, excretions, mucous membranes, non-intact skin, or wound dressing (if hands aren't visibly soiled); g. After removing gloves;. Review of the facility policy titled Enhanced Barrier Precautions, dated 02/25/25, provided by the facility revealed b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting. h. Wound care: any skin opening requiring a dressing. Review of the facility policy titled Linen Management, revised 08/21/25, provided by the facility, revealed 5. Dirty linens are contained in a closed container or bag. 6. Dirty linens are to be handled in a way to prevent aerosolizing infectious agents (i.e.do, not shake linens).		