STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525519	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Age of Brookfield	1755 N Barker Rd Brookfield, WI 53045

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not report 1 (R2) of 2 incidents to the State Survey Agency and/or Nursing Home Administrator during the required timeframe. On 12/7/24 NHA (Nursing Home Administrator) was informed of a skin tear on R2's left wrist which CNA (Certified Nursing Assistant)-G reported to LPN (Licensed Practical Nurse)-E as occurring when taking off R2's sweat shirt. NHA-A was not informed on 12/7/24 of R2's allegation the skin tear occurred when CNA-G grabbed her arm. The allegation of CNA-G grabbing R2's arm was reported to DON (Director of Nursing)-B on 12/7/24 but DON-B did not report this to the State agency. The allegation of physical abuse was not reported to NHA-A or the State agency until 12/9/24. Findings include: The facility's policy titled, Abuse, Neglect and Exploitation and last reviewed/revised 9/22/23 under policy documents: It is the policy of [name of facility] to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under the section VII. Reporting/Response documents A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe's: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R2's diagnoses includes osteoarthritis, anxiety disorder, hypertension, essential tremor, and depressive disorder. R2's annual MDS (minimum data set) with an assessment reference date of 11/27/24 has a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. R2 requires substantial/maximal assistance for toileting hygiene, rolling left & right, lying to sitting on the edge of the bed , chair/bed to chair transfers and toilet transfers. Walk 10 feet and walk 50 feet with two turns is assessed as partial/moderate assistance. R2 is assessed as frequently incontinent of urine and occasionally incontinent of bowel. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The cognitive loss/dementia CAA (care area assessment) was not triggered. The Functional Abilities (Self-Care and Mobility) CAA dated 12/10/24 under Care Plan Considerations documents Is a long term resident. Needs assist with ambulation, locomotion, dressing, hygiene, toileting, bathing, bed mobility, and transfers. BIMS 13. Diagnosis includes arthritis, PAF (Paroxysmal Atrial Fibrillation), and venous insufficiency. Proceed to care plan functional abilitities. R2's nurses note dated 12/7/24, at 20:41 (8:41 p.m.) documents CNA (Certified Nursing Assistant) reported when she took off residents sweat shirt resident said I'm bleeding and CNA came to get the nurse. Noted 4.5 cm (centimeter) x (times) 4 cm skin tear to left wrist. Skin tear cleansed with NS (normal saline) approximated and steri stripped. [Medical Group Name] [Name] PA (Physician Assistant) updated on call RN (Registered Nurse) Manager updated. This nurses note was written by LPN (Licensed Practical Nurse)-E. On 1/15/25, at 11:48 a.m., Surveyor reviewed the Facility Reported Incident involving R2 with date of occurrence documented 12/7/24, date discovered is documented as 12/9/24, and date reported is 12/9/24. On 1/15/25, at 2:42 p.m., Surveyor interviewed LPN-E regarding her nurses note dated 12/7/24. LPN-E informed Surveyor CNA-G told her when she was taking off R2's sweatshirt she got a skin tear. LPN-E informed Surveyor she asked CNA-G how R2 received the skin tear as it was a large skin tear. LPN-E informed Surveyor R2 said she just knows after the CNA took off her shirt she was bleeding when the CNA was in the room. LPN-E informed Surveyor she called the nurse manager right away regarding R2's skin tear. LPN-E informed when she went back to R2's room and CNA-G was not in the room, R2 told her the CNA grabbed to arm to put her in bed. Surveyor asked LPN-E after R2 told you the CNA grabbed her arm did you notify the RN Manager know. LPN-E replied yes and then they did an investigation. Surveyor asked LPN-E who the nurse manager was. LPN-E replied [name of] RN Manager-F. On 1/16/25, at 8:15 a.m., Surveyor interviewed RN Manager-F regarding R2's skin tear which occurred on 12/7/24. Surveyor asked RN Manager-F if she was in the building. RN Manager-F informed Surveyor she was on call and not in the facility. Surveyor asked RN Manager-F how she became aware of R2's skin tear. RN Manager-F replied the floor nurse and thought it was name of LPN-E. Surveyor asked RN Manager-F if she remembers what LPN-E said to her. RN Manager-F stated R2 got a skin tear and thinks she received the skin tear when the CNA was getting her ready for bed. The CNA wasn't exactly sure how it happened and notified her (LPN-E) of the skin tear. RN Manager-F informed Surveyor she called NHA (Nursing Home Administrator)-A to let her know of the skin tear as R2 had said wait until her son hears. RN Manager-F explained a lot of times the son will skip over everyone and goes to NHA-A. Surveyor asked RN Manager-F after LPN-E's initial call to her did LPN-E call her back. RN Manager-F replied she text me later. Surveyor asked what did LPN-E text her. RN Manager-F informed Surveyor R2 was upset and R2 said she received the skin tear when the CNA grabbed her arm. RN Manager-F informed Surveyor not to down play but R2 can be very particular on how she wants her cares, R2 will tell you what she wants and can get persnickety. Surveyor asked RN Manager-F if she called NHA-A back after she was informed R2 had said the CNA grabbed her arm. RN Manager-F replied I did not because she was in Chicago, figured I'd call [first name of] DON (Director of Nursing)-B. Surveyor asked RN Manager-F what she told DON-B. RN Manger-F replied the CNA grabbed her arm. Surveyor asked RN Manager-F if she was given any instructions from DON-B. RN Manager-F informed Surveyor the CNA wasn't staying for the whole shift, not working the next day (Sunday) and they were going to look at it on Monday. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25, at 8:49 a.m., Surveyor asked DON-B when she became aware of R2's skin tear which occurred on 12/7/24. DON-B replied think they called me that night. I had [first name of CNA-G] sent home after her statement. DON-B informed Surveyor she wants to say LPN-E called her that they have an issue with [name of resident]'s skin. Surveyor asked if RN Manager-F called her. DON-B informed Surveyor RN Manager-F called her to report what was going on with R2 and CNA-G was sent home after her statement. Surveyor asked DON-B if she was made aware R2's allegation of CNA-G grabbing her arm. DON-B informed Surveyor that's what R2 told LPN-E. Surveyor asked DON-B if she notified the State on 12/7/24. DON-B replied no I did not. Surveyor asked DON-B why she didn't report the allegation to the State agency. DON-B replied I was still investigating. DON-B informed Surveyor R2 has a history of accusing staff that's why she wanted to look into it more before going forward with anything else. Surveyor asked DON-B when the last time R2 made an accusation about staff. DON-B replied I don't know, I really have to look, don't know the answer off the top of my head. Surveyor asked DON-B to look into when R2 last made an accusation and get back to Surveyor. On 1/16/25, at 9:39 a.m., DON-B informed Surveyor September was the last time R2 accused a CNA or staff of doing something that wasn't intentional. On 1/16/25, at 11:01 a.m., Surveyor asked NHA-A why R2's allegation of CNA-G grabbing her arm which resulted in a skin tear on 12/7/24 wasn't reported until 12/9/24. NHA-A informed Surveyor when she was initially called the initial report didn't say anything about the CNA grabbing R2's arm. NHA-A informed the skin tear was written up as a grievance. NHA-A informed Surveyor when she came in Monday (12/9/24), R2's son called her and at some point she went to speak to R2. When she spoke with R2 it was different than what she was told and so she did a self report. Surveyor informed NHA-A Surveyor spoke with RN Manager-F who informed Surveyor she had called her (NHA-A) about R2's skin tear but didn't call NHA-A back as she didn't want to bother NHA-A as she was in Chicago. RN Manager-F informed Surveyor she called DON-B. Surveyor asked DON-B if she reported the allegation of CNA-G grabbing R2's arm on 12/7/24 and Surveyor was informed by DON-B she didn't. Surveyor informed NHA-A R2's allegation should have been reported on 12/7/24. No additional information was provided to Surveyor as to why the facility did not report R2's allegation until 12/9/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 20483 Based on interview and record review the facility did not ensure 1 (R2) of 4 residents care plans were revised. R2's care plan was not revised after an allegation on 12/7/24 of a CNA grabbing R2's wrist causing a skin tear. Findings include: The facility's policy titled, Care Plan Revisions Upon Status Change and implemented 10/21/24 under Policy documents The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Under Policy Explanation and Compliance Guidelines documents 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. R2's diagnoses includes osteoarthritis, anxiety disorder, hypertension, essential tremor, and depressive disorder. The ADL (Activities Daily Living) Functional Potential/Rehabilitation and/or Limited Mobility care plan initiated 9/29/23 documents the following interventions: *Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated. Initiated 9/29/23. *Bathing/Showering: Resident prefers showers. Initiated 9/29/23 & revised 10/3/24. *Bathing/Showering: The resident is dependent on (1) staff to provide bath/shower. Initiated & revised 9/29/23. *Do not disturb resident between Midnight and 0800 (8:00 a.m.) unless call light is on. Initiated 11/13/23. *Dressing-Resident will have the option to wear gown or other item of choice for sleeping. Initiated 4/24/24. *Eating: The resident needs setup or clean up assistance to eat. Initiated 9/29/23. *Lower Body dressing: The resident is dependent on (1) staff for dressing. Initiated & revised 9/29/23. *Lying to sitting on the side of the bed: The resident requires substantial/maximum assistance by (1) staff to complete task. Initiated & revised 9/29/23. Mobility: The resident uses manual wheelchair. Initiated 9/29/23. *Oral Care: The resident needs moderate/clean up assistance with oral care assist with brushing and flossing twice daily am/eve (morning/evening) and antibacterial rinse to follow. Initiated 9/29/23 & revised 3/21/24. *Personal Hygiene: The resident is dependent on (1) staff for personal hygiene. Initiated & revised 9/29/23. *Putting on or taking off shoes: The resident is dependent on staff to complete. Initiated 9/29/23. *Roll left and right: The resident requires substantial/maximum assistance on (1) staff to complete. Initiated & revised 11/24/24. *The resident has no weight bearing restrictions. Initiated: 9/29/23. *Toileting Transferring: The resident needs substantial/maximum (1) staff assistance to complete task. Initiated & revised 11/24/24. *Toileting Transferring: The resident needs partial/moderate assistance of 1 staff assistance to complete task. Initiated 9/29/23. *Transfer: The resident needs partial/moderate assistance of 1 staff for transferring. Initiated 9/29/23. *Upper Body Dressing: The resident is dependent on (1) staff for dressing. Initiated 9/29/23 & revised 8/23/24. *Walk 10 FT (feet): The resident requires substantial/maximum assistance on 1 staff to complete task. Initiated 9/29/23. *Walk 10 FT: The resident uses a [2 wheeled walker] [standard walker] for walking. Initiated & revised 9/29/23. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's annual MDS (minimum data set) with an assessment reference date of 11/27/24 has a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. R2 requires substantial/maximal assistance for toileting hygiene, rolling left & right, lying to sitting on the edge of the bed , chair/bed to chair transfers and toilet transfers. Walk 10 feet and walk 50 feet with two turns is assessed as partial/moderate assistance. R2 is assessed as frequently incontinent of urine and occasionally incontinent of bowel. The Visual/Bedside Kardex Report located in R2's bathroom dated 12/9/24 under the section Resident Care documents * DRESSING-Resident will have the option to wear gown or other item of choice for sleeping. Under the section Mobility documents * MOBILITY: The resident needs substantial/maximum assistance for 1 staff for mobility. * MOBILITY: The resident uses manual wheelchair. *WALK 10 FT (feet): The resident requires substantial/maximum assistance on 1 staff to complete task. *WALK 10 FT: The resident uses a [2 wheeled walker] [standard walker] for walking. On 1/15/25, at 10:32 a.m., Surveyor observed CNA (Certified Nursing Assistant)-C enter R2's room and ask R2 if she was ready to get up. CNA-C removed the bedding, removed gripper socks, and placed tubi grips & gripper socks on R2. CNA-C opened R2's closet and gave R2 choices of what to wear. CNA-C placed gloves on and asked R2 if she wanted the door open or closed. R2 stated open and CNA-C explained to Surveyor R2 is claustrophobic. CNA-C stated to R2 you do your thing. R2 grabbed onto the left transfer bar stating I try to get out of bed by myself. Resident then asked CNA-C to swing her legs so she was sitting on the edge of the bed. CNA-C placed the walker next to R2, raised the head of the bed up high and then R2 stated I don't have to tell her, she knows what to do. CNA-C placed a towel on top of the cushion in the wheelchair and then raised the height of the bed up telling R2 let me know when. R2's bed was raised up until R2 slid with her feet on the floor while R2 held onto the walker & wheelchair. After R2 was standing up, R2 sat in the wheelchair. CNA-C wheeled R2 into the bathroom. CNA-C explained in the evening R2 likes to be wheeled into the bathroom and walk back to bed with a walker. CNA-C then placed powder on the toilet seat. R2 explained to Surveyor she sticks to the toilet seat. R2 held onto the grab bar, stood up, took a couple steps to turn and sat on the toilet. CNA-C removed her gloves, washed her hands, and placed gloves on. R2 washed her face, CNA-C removed R2's gown, washed R2's upper body & placed a sweatshirt on R2. CNA-C placed an incontinence product and pants on R2, moved the wheelchair closer and then R2 grabbed onto the grab bar and stood up. CNA-C washed R2's frontal perineal area & buttocks, applied barrier cream and pulled up incontinence product & pants. R2 sat in wheelchair. On 1/15/25, at 2:11 p.m., Surveyor asked CNA-C if she heard any concerns regarding CNA-G. CNA-C replied just from first name of R2. CNA-C explained CNA-G did a double and didn't do what R2 wanted her to do going to bed, grabbed her wrist that's how she got her skin tear. On 1/16/25, at 10:20 a.m., Surveyor spoke with CNA-D on the telephone regarding R2 on 12/7/24. CNA-D explained R2 was already in bed with a sweater. CNA-D informed Surveyor R2 never is in bed with a sweater as she takes it off before going to bed. CNA-D informed Surveyor the CNA was confused on how to put R2 to bed. CNA-D explained R2 walks back from the bathroom to the bed with a walker. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25, at 11:01 a.m., Surveyor met with NHA (Nursing Home Administrator)-A regarding R2's allegation on 12/7/24 when CNA-G grabbed R2's arm which resulted in a skin tear. Surveyor reviewed this facility reported incident. Surveyor asked NHA-A if there was any change in R2's plan of care after this incident to prevent a further occurrence. Surveyor informed NHA-A Surveyor observed morning cares on 1/15/25. Surveyor explained to NHA-A how R2 has a certain routine of how to gets out of bed and was informed in the evening R2 is wheeled into the bathroom and then she walks back to bed with a walker. Surveyor also informed NHA-A R2 likes to have the room door open as she is claustrophobic. Surveyor informed NHA-A none of R2's interventions address what R2 likes and asked how would a CNA who hasn't taken care of R2 prior know this. NHA-A informed Surveyor she doesn't recall and will have to ask. On 1/16/25, at 12:25 p.m. NHA-A provided Surveyor with R2's Visual/Bedside Kardex Report dated 1/16/25. Surveyor noted the Resident Care section has been updated with the following: *Prefers to keep her door open even while cares are being performed per her preference and *Toileting in the evening: Will ambulate from BR (bathroom) to bed with wheeled walker but will not ambulate from bed to BR per her choice. Do not rush her. On 1/16/25, at 1:27 p.m., Surveyor met with NHA-A and DON-B. Surveyor asked if the interventions on the Kardex come from the care plan. DON-B replied yes. Surveyor asked why the care plan was not revised prior to Surveyor asking. DON-B informed Surveyor she doesn't want to throw anyone under the bus and stated she delegated it and didn't follow up to make sure it was done. Surveyor asked for a copy of R2's revised care plans. On 1/16/25, at 1:56 p.m., Surveyor was provided with R2's care plans. The ADL Functional Potential/Rehabilitation and/or Limited Mobility care plan initiated 9/29/23 was revised with the following interventions: *Prefers to keep her door open even while cares are being performed per her preference. Initiated 1/16/25. *Toileting in the evening: Will ambulate from BR to bed with wheeled walker but will not ambulate from bed to BR per her choice. Do not rush her. Initiated 1/16/25. No additional information was provided as to why R2's care plans were not revised prior to Surveyor inquiring on 1/16/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observations, interviews and record reviews, the facility did not provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 5 (R3, R5, R6, R7 and R8) of 7 residents reviewed for medications. *R3, R5, R6, R7 and R8 had MD orders for narcotic pain medication. Facility staff did not consistently document the administration time of the pain medication directly after administering the pain medication as outlined in the facility policy. The late documentation could result in duplication of pain medication administration. *R5 had duplicate Medical Doctor (MD) orders for Oxycodone (a narcotic pain medication). Facility staff were using both MD orders for documenting the administration of Oxycodone. Findings include: The Wisconsin State Regulation entitled, DHS 132.60(5)(d)2. documents, in part: . Responsibility for administration. Policies and procedures designed to provide safe and accurate acquisition, receipt, dispensing and administration of medications shall be developed by the facility and shall be followed by personnel assigned to prepare and administer medications and to record their administration. The same person shall prepare, administer, and immediately record in the resident's clinical record the administration of medications. The facility policy dated May 2018, titled, Preparation and General Guidelines. Medication Administration-General Guidelines documents, in part: Medications are administered as prescribed in accordance with good nursing principles and practices . Documentation (including electronic) . The individual who administers the medication dose records the administration on the resident's MAR/eMAR [Medication Administration Record/electronic Medication Administration Record] directly after the medication is given . On 1/16/25, Director of Nursing supplied the above Medication Administration Policy to Surveyor. Surveyor asked if the Medication Administration policy had been changed recently. DON-B stated No. 1.) R3 was admitted to the facility on [DATE] with diagnosis that includes dementia, and recent hospitalization for sepsis and right lower extremity fractures. R3's Admission Minimum Data Set (MDS) assessment dated [DATE] documents R3 is severely cognitively impaired. R3 has pain almost constantly and the pain will occasionally affect R3's sleep. R3's Medical Doctor (MD) order, dated 9/18/24, documents: Oxycodone HCL Tablet 5 milligrams (MG). Give 5MG by mouth every 6 hours as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R3's Medication Administration Record (MAR) and R3's Orders administration note within the electronic medical record. Surveyor noted that the time entered on R3's MAR as the administration time was not documented directly after medication administration. Surveyor noted 12 times that R3's medication administration was documented later in the day. Examples include: -On 9/20/24, Licensed Practical Nurse (LPN)-H documented Oxycodone 5MG was administered at 9PM. This administration note was created at 10:58 PM, which is 1 hour and 58 minutes later. -On 9/27 24, LPN-I documented Oxycodone 5MG was administered at 10:36 AM. This administration note was created at 1:37 PM, which is 3 hours and 1 minute later. -On 9/28/24, LPN-I documented Oxycodone 5MG was administered at 8:35 AM. This administration note was created at 9:05 AM, which is 40 minutes later. -On 9/29/24, LPN-I documented Oxycodone 5MG was administered at 8:21 AM. This administration note was created at 1:22 PM, which is 5 hours and 1 minute later. -On 10/6/24, LPN-H documented Oxycodone 5MG was administered at 3:02 PM. This administration note was created at 10:03 PM, which is 7 hours and 1 minute later. -On 10/6/24, LPN-H documented Oxycodone 5MG was administered at 9:20 PM. This administration note was created at 10:04 PM, which is 44 minutes later. -On 10/12/24, LPN-I documented Oxycodone 5MG was administered at 9:28 AM. This administration note was created at 11:29 PM, which is 2 hours and 1 minute later. -On 10/17/24, LPN-I documented Oxycodone 5MG was administered at 7:05 AM. This administration note was created at 4:15 PM, which is 9 hours and 10 minutes later. -On 10/22/24, LPN-I documented Oxycodone 5MG was administered at 7:15 AM. This administration note was created at 12:39 PM, which is 5 hours and 24 minutes later. -On 10/25/24, LPN-H documented Oxycodone 5MG was administered at 9:30 PM. This administration note was created at 10:51 PM, which is 1 hour and 21 minutes later. -On 10/26/24, LPN-I documented Oxycodone 5MG was administered at 8:08 AM. This administration note was created at 2:26 PM, which is 6 hours and 18 minutes later. -On 10/26/24, LPN-H documented Oxycodone 5MG was administered at 4:15 PM. This administration note was created at 5:35 PM, which is 1 hour and 20 minutes later. Surveyor noted these 12 examples include late documentation up to 9 hours and 10 minutes later than the medication was administered. Surveyor noted in these 12 examples, staff did not follow facility policy or Wisconsin State Regulation that indicate staff should immediately record in the resident's clinical record the administration of medications. Surveyor noted during the time the medication was given but not documented, another facility staff could have come along and saw the medication was not given and administer the medication again. This could potentially cause a medication error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) Surveyor reviewed R5's MAR and R5's Orders administration note within R5's electronic medical record. Surveyor noted that the time entered on R5's MAR as the administration time was not documented directly after medication administration. Surveyor noted 11 times that R5's medication administration was documented later in the day. Examples include: -On 10/25/24, Licensed Practical Nurse (LPN)-H documented Oxycodone 5MG was administered at 8:34 PM. This administration note was created at 10:54 PM, which is 2 hours and 20 minutes later. -On 10/29/24, LPN-I documented Oxycodone 5MG was administered at 12:04 PM. This administration note was created at 2:04 PM, which is 2 hours later. -On 10/29/24, Registered Nurse (RN)-K documented Oxycodone 10MG was administered at 2:45 PM. This administration note was created at 3:46 PM, which is 1 hour and 1 minute later. -On 10/30/24, LPN-I documented Oxycodone 10MG was administered at 8:02 AM. This administration note was created at 8:22PM, which is 20 minutes later. -On 10/30/24, LPN-H documented Oxycodone 10MG was administered at 3:30 PM. This administration note was created at 6:28 PM, which is 2 hours and 58 minutes later. -On 10/30/24, LPN-H documented Oxycodone 10MG was administered at 8 PM. This administration note was created on 10/31/24 at 00:21 AM, which is 4 hours and 21 minutes later. -On 10/31/24, LPN-I documented Oxycodone 10 MG was administered at 7:30 AM. This administration note was created at 8:13 AM, which is 43 minutes later. -On 11/5/24, LPN-I documented Oxycodone 10 MG was administered at 7 AM. This administration note was created at 7:45 AM, which is 45 minutes later. -On 11/7/24, LPN-I documented Oxycodone 10 MG was administered at 7 AM. This administration note was created at 7:32 AM, which is 32 minutes later. -On 11/9/24, LPN-I documented Oxycodone 10 MG was administered at 7:15 AM. This administration note was created at 9:05 AM, which is 1 hour and 50 minutes later. -On 11/13/24, LPN-I documented Oxycodone 10 MG was administered at 8:02 AM. This administration note was created at 11:51 AM, which is 3 hours and 49 minutes later. Surveyor noted these 11 examples include late documentation up to 4 hours and 21 minutes later than the medication was administered. Surveyor noted in these 11 examples, staff did not follow facility policy or Wisconsin State Regulation that documents staff should immediately record in the resident's clinical record the administration of medications. Surveyor noted that during the time the medication was given but not documented, another facility staff could have come along and saw that the medication was not given and administer the medication again. This could potentially cause a medication error. 3.) R6 was admitted to the facility on [DATE] with diagnosis that include Wedge compression fracture of T11-T12 Vertebra, Subsequent encounter for fracture with delayed healing, and Low back pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525519	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Age of Brookfield	1755 N Barker Rd Brookfield, WI 53045

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's Admission Minimum Data Set (MDS) assessment dated [DATE] documents R6 is cognitively intact. R6 has pain almost constantly. R6's pain occasionally affects R's sleep and almost constantly interferes with day-to-day activity. R6's MD order dated 10/24/24 and discontinued on 10/30/24 documents, Hydrocodone-Acetaminophen tablet 5-325 milligrams (MG). Give 1 tablet by mouth every 4 hours for pain. R6's MD order dated 10/30/24 and discontinued on 11/4/24 documents, Oxycodone HCL oral tablet 5MG. Give 1 tablet by mouth every 6 hours as needed for pain. R6's MD order dated 11/4/24 and discontinued 11/15/24 documents, Oxycodone HCL oral tablet 5MG. Give 1 tablet by mouth every 6 hours as needed for pain. Surveyor reviewed R6's Medication Administration Record (MAR) and R6's Orders administration note within R6's electronic medical record. Surveyor noted that the time entered on R6's MAR as the administration time was not documented directly after medication administration. Surveyor noted 11 times R6's medication administration was documented later in the day. Examples include: -On 10/25/24, Licensed Practical Nurse (LPN)-H documented Hydrocodone-Acetaminophen 5-325MG was administered at 8:10 PM. This administration note was created at 10:49 PM, which is 2 hours and 39 minutes later. -On 10/26/24, LPN-I documented Hydrocodone-Acetaminophen 5-325MG was administered at 1:01 PM. This administration note was created at 2:21 PM, which is 1 hour and 20 minutes later. -On 10/26/24, LPN-H documented Hydrocodone-Acetaminophen 5-325MG was administered at 9PM. This administration note was created at 00:55 AM, which is 3 hours and 55 minutes later. -On 10/27/24, LPN-I documented Hydrocodone-Acetaminophen 5-325MG was administered at 1:29 PM. This administration note was created at 2:29 PM, which is 1 hour later. -On 10/28/24, RN-K documented Hydrocodone-Acetaminophen 5-325MG was administered at 4:45 PM. This administration note was created at 6:22 PM, which is 1 hour and 37 minutes later. -On 10/30/24, LPN-I documented Oxycodone 5MG was administered at 10:32 AM. This administration note was created at 12:56 PM, which is 2 hours and 24 minutes later. -On 10/30/24, LPN-H documented Oxycodone 5MG was administered 4:30PM. This administration note was created at 5:24 PM, which is 54 minutes later. -On 10/30/24, LPN-H documented Oxycodone 5MG was administered at 10:30 PM. This administration note was created on 10/31/24 at 00:19, which is 1 hour and 49 minutes later. -On 11/7/24, LPN-I documented Oxycodone 5MG was administered at 8:30 AM. This administration note was created at 11:13 AM, which is 2 hours and 43 minutes later. -On 11/9/24, LPN-I documented Oxycodone 5MG was administered at 8:16 AM. This administration note was created at 1:16 PM, which is 5 hours later. (continued on next page)

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Care Age of Brookfield	1755 N Barker Rd Brookfield, WI 53045

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 11/13/24, LPN-I documented Oxycodone 5MG was administered at 7:16 AM. This administration note was created at 11:44 AM, which is 4 hours and 28 minutes later. Surveyor noted that these 11 examples include late documentation up to 5 hours later than the medication was administered. Surveyor noted that in these 11 examples, staff did not follow facility policy or Wisconsin State Regulation that documents staff should immediately record in the resident's clinical record the administration of medications. Surveyor noted that during the time the medication was given but not documented, another facility staff could have come along and saw that the medication was not given and administer the medication again. This could potentially cause a medication error. 4.) R7 was admitted to the facility on [DATE] with diagnosis that include Aftercare following joint replacement surgery, Fibromyalgia and Chronic pain Syndrome. R7's Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] documents that R7 is cognitively intact. R7 had pain almost constantly. R7's pain frequently affects R7's sleep. R7's MD order with a start date of 10/23/24 documents Oxycodone HCL tablet 5 milligrams (MG). Give 2 tablets by mouth every 6 hours as needed for pain. Surveyor reviewed R7's Medication Administration Record (MAR) and R7's Orders administration note within R7's electronic medical record. Surveyor noted that the time entered on R7's MAR as the administration time was not documented directly after medication administration. Surveyor noted 2 times that R7's medication administration was documented later in the day. Examples include: -On 10/24/24, Licensed Practical Nurse (LPN)-H documented Oxycodone 10MG was administered at 4PM. This administration note was created at 4:17 PM, which is 17 minutes later. -On 10/28/24, LPN-H documented Oxycodone 10MG was administered at 10:10 PM. This administration note was created at 11:15 PM, which is 1 hour and 5 minutes later. Surveyor noted that these 2 examples include late documentation up to 1 hour and 5 minutes later than the medication was administered. Surveyor noted that in these 2 examples, staff did not follow facility policy or Wisconsin State Regulation that documents staff should immediately record in the resident's clinical record the administration of medications. Surveyor noted that during the time the medication was given but not documented, another facility staff could have come along and saw that the medication was not given and administer the medication again. This could potentially cause a medication error. 5.) R8 was admitted to the facility on [DATE] with diagnosis that include Cellulitis of left lower limb, Osteoarthritis, and chronic pain syndrome. R8's Admission Minimum Data Set (MDS) assessment dated [DATE] documents R8 is cognitively intact. R8 has pain frequently. R8's pain frequently affects R8's sleep. R8's MD order with a start date of 10/2/24 documents Oxycodone HCL tablet 5 milligrams (MG). Give 1 tablet by mouth every 6 hours as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's MD order with a start date of 10/2/24 documents Oxycodone HCL tablet 5MG. Give 2 tablets by mouth every 6 hours as needed for pain. Surveyor reviewed R8's Medication Administration Record (MAR) and R8's Orders administration note within R8's electronic medical record. Surveyor noted that the time entered on R8's MAR as the administration time was not documented directly after medication administration. Surveyor noted 8 times that R8's medication administration was documented later in the day. Examples include: -On 10/3/24, Licensed Practical Nurse (LPN)-H documented Oxycodone 10MG was administered at 4PM. This administration note was created at 7:50PM, which is 3 hours and 50 minutes later. -On 10/6/24, LPN-H documented Oxycodone 10MG was administered at 2:30 PM. This administration note was created at 2:54PM, which is 24 minutes later. -On 10/10/24, LPN-I documented Oxycodone 10MG was administered at 10:30 AM. This administration note was created at 10:57 AM, which is 27 minutes later. -On 10/12/24, LPN-I documented Oxycodone 10MG was administered at 10:20 AM. This administration note was created at 4:21 PM, which is 5 hours and 1 minute later. -On 10/13/24, LPN-I documented Oxycodone 10MG was administered at 11 AM. This administration note was created at 11:49 AM, which is 49 minutes later. -On 10/15/24, LPN-I documented Oxycodone 10MG was administered at 7:08 AM. This administration note was created at 3:08 PM, which is 8 hours later. -On 10/17/24, LPN-I documented Oxycodone 5MG was administered at 6:45 AM. This administration note was created at 8:20 AM, which is 1 hour and 35 minutes later. -On 10/23/24, RN-K documented Oxycodone 10MG was administered at 9:50 PM. This administration note was created at 11:07 PM, which is 1 hour and 17 minutes later. Surveyor noted that these 8 examples include late documentation up to 8 hours later than the medication was administered. Surveyor noted that in these 8 examples, staff did not follow facility policy or Wisconsin State Regulation that documents staff should immediately record in the resident's clinical record the administration of medications. Surveyor noted that during the time the medication was given but not documented, another facility staff could have come along and saw that the medication was not given and administer the medication again. This could potentially cause a medication error. On 1/15/25, at 2:10 PM, Surveyor interviewed Registered Nurse (RN)-J. Surveyor asked when a medication administration time should be documented. RN-J stated that RN-J will always document the administration of a medication as soon as the medication is administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25, at 2:20 PM, Surveyor interviewed RN-K. Surveyor asked when a medication administration time should be documented. RN-K stated it should be documented at the same time as the medication was administered. Surveyor asked if a medication would ever be documented hours after the medication administration. RN-K stated it shouldn't be documented like that, but in a rare circumstance like being pulled away to do something else or deal with something urgent, it may be documented later. RN-K indicated that best practice would be to document at the time of administration. On 1/16/25 at 8:35 AM, Surveyor observed LPN-I administering medications. Licensed Practical Nurse (LPN)-I documented the administration of medications immediately after administering the medications. On 1/16/25, at 8:45 AM, Surveyor interviewed LPN-I. Surveyor asked how long LPN-I had been working in the facility. LPN-I stated LPN-I had worked [AGE] years in the facility. Surveyor asked if in the past, LPN-I had documented the administration of medications later than immediately after the administration. LPN-I stated over the years, yes. LPN-I continued and indicated that after a recent incident regarding diverging of medication involving a different nurse, LPN-I did not document the administration late anymore. LPN-I stated that LPN-I would sometimes forget to put the documentation into the electronic medical record and sign out the narcotic pain medication until later in the day. LPN-I indicated there were times that LPN-I was at home when LPN-I remembered that documentation was not completed. On 1/16/25, at 11:25 AM, Surveyor interviewed RN Manager-F. Surveyor asked if facility staff can document a medication administration hours after it was given. RN-F stated that facility staff can back time a medication administration, if needed. Surveyor asked when documentation of a medication administration should occur. RN-F stated that after a medication if given, it should immediately be documented as given. Surveyor informed RN-F of facility staff documenting the administration of medications sometimes hours after the administration. Surveyor asked if RN-F was concerned about the late documentation. RN-F stated yes, it is not best practice. On 1/16/25, at 12:55 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor asked when a medication administration should be documented. DON-B stated the minute that the medication is given. DON-B stated that through an investigation relating to diverting medication that occurred on 10/30/24, DON-B noted that staff were not always signing out a medication administration on the MAR. Surveyor informed DON-B and NHA-A that facility staff were not always documenting the medication administration time on the MAR immediately after the medication was given. Surveyor gave examples of documentation being completed up to 9 hours after the medication administration. Surveyor asked if DON-B would be concerned about documenting medication administration that long after giving a medication. DON-B stated that 9 hours is ridiculous, especially since staff have 8-hour shifts. DON-B stated that DON-B would be concerned. On 1/16/25, at 3:32 PM, DON-B stated that DON-B reviewed medication administration times on a few facility staff members for the last month. DON-B stated that LPN-I did not have any long gaps in between medication administration and documentation of the administration. DON-B stated that RN-K did have one instance of about an hour difference in documentation. DON-B stated that DON-B will complete education and will audit. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/25 at 1:17 PM, NHA-A sent Surveyor additional information for review. Surveyor reviewed the additional information however Surveyor notes current noncompliance was identified at this regulation. 6.) R5 was admitted to the facility on [DATE] with diagnosis that include: Infection and inflammatory reaction due to internal right knee prosthesis. R5's Admission Minimum Data Set (MDS) assessment dated [DATE] documents R5 has intact cognition. R5 has pain almost constantly which frequently affects R5's sleep. R5's Medical Doctor (MD) order dated 10/24/24 with a discontinue date of 11/16/24 documents: Oxycodone HCL oral tablet 5 milligrams (MG). Give 1 tablet by mouth every 4 hours as needed for Pain Management. R5's Progress note dated 10/25/24, at 4:36 PM, documents in part, New Order Received to increase As Needed Oxycodone to 1 or 2 tabs every 4 hours as needed . R5's MD order dated 10/25/24 with a discontinue date of 10/28/24 documents: Oxycodone HCL oral tablet 5 MG. Give 2 tablet by mouth every 4 hours as needed for Pain. Give 1-2 tablets by mouth every 4 hours as needed for Pain Management. R5's MD order dated 10/28/24 with a discontinue date of 11/16/24 documents: Oxycodone HCL oral tablet 5 MG. Give 1 tablet by mouth every 4 hours as needed for Pain. R5's MD order dated 10/28/24 with a discontinue date of 11/16/24 documents: Oxycodone HCL Oral Tablet 5 MG. Give 2 tablets by mouth every 4 hours as needed for pain. Surveyor noted that from 10/28/24 through 11/16/24, R5 had a duplicate order of one tablet of Oxycodone. Surveyor reviewed R5's Medication Administration Record (MAR) and noted that facility staff would document the administration of one 5MG tablet in either the order started on 10/24/25 or the order started on 10/28/24. Surveyor noted this could cause confusion and the possibility of giving more medication because the documentation was split between the two orders on the MAR. On 1/16/25, at 12:55 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor informed NHA-A and DON-B that R5 had duplicate orders of Oxycodone 5MG. DON-B indicated that R5's dose was increased to 1 to 2 tabs every four hours as needed on 10/25/24. Surveyor informed DON-B and NHA-A of the concern that when the new order was received the previous order was not discontinued thus leaving a duplicate order for facility staff to document administrations on in the MAR. No further information was provided regarding the duplicate one tab of 5MG Oxycodone order. .