STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525556	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	3506 Washington Rd Kenosha, WI 53144

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** 49845 Based on interview and record review the facility did not report 1 (R12) of 3 reportable incidents to the State survey agency and/or Law Enforcement within the required timeframe. *On 02/12/2025, The facility was made aware of R12's missing narcotic medication. The facility did not notify the State Agency at any point, and did not notify Law Enforcement until 02/28/2025. Findings: The facility Policy, titled ABUSE, NEGLECT, MISAPPROPRIATION, EXPLOITATION, MISTREATMENT, dated 10/26/2016, documents the following, Policy: . It is the policy of this facility that all allegations of abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation of resident property are reported per Federal and State Law. or not later than 24 hours if the events that cause the allegations do not involve abuse and no not result in serious bodily injury, to the Administrator of the facility and to other state officials in accordance with Federal and Wisconsin Law, through established procedures. 7. Reporting: Employees must always report an abuse or suspicion of abuse IMMEDIATELY to the Supervisor on duty . B. The Supervisor on duty will notify the Administrator of the allegation. The Administrator will involve key leadership personnel as necessary to assist with the reporting, investigating and follow up. C. If an incident is considered reportable. The Administrator or designee will make an initial (immediate within 24 hours) report to the Division of Quality Assurance Office of Care Giver Quality. E. Law Enforcement will be notified immediately but no later than two hours if there is suspicion of a crime / or alleged sexual abuse as required by the Elder Justice Act. Surveyor reviewed a complaint sent into the State Agency regarding allegations of narcotic/medication diversions had occurred at the facility in February 2025. Surveyor, along with a team of Surveyors, entered the facility on 03/10/2025 to complete a complaint and verification survey. Surveyor requested facility Investigations from 12/2024 to current. The facility provided two facility reported investigations, Surveyor noted neither were related to medication diversion. (continued on next page)

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	On 03/10/2025, at 10:53 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E, on the 400 unit, regarding the procedures for Narcotic medications. LPN-E indicated all narcotic medications are kept in a [NAME] box on the medication cart. LPN-E indicated that 2 nurses will now perform the narcotic medication count in the medication room in front of the camera. Surveyor asked LPN-E if narcotic medication count in the medication room was a newly implemented procedure. LPN-E indicated being unsure if the procedure is new, but indicated an email was sent out last month (February) indicating to ensure medication counts are done in the medication room in front of the camera. Surveyor preformed a narcotic medication count with LPN-E. Surveyor noted, no discrepancies identified with the narcotic medication count. On 03/10/2025, at 11:04 AM, Surveyor interviewed LPN-K, on the 500 unit, regarding the procedures for Narcotic medications. LPN-K indicated that Narcotic medications are kept in the [NAME] box of the medication cart. LPN-K indicated counts are down with 2 nurses and the beginning and end of each shift. LPN-K indicated that the Narcotic medication counts were not always preformed in the medication room and indicated that in February of 2025, on this unit (500 unit), there was an incident where a Narcotic medications were missing. LPN-K indicated the facility was aware and after the incident, staff are now to count Narcotic medications in the medication room in front of the camera. LPN-K indicated there was training and re-education provided by the facility following the incident. LPN-K indicated destruction of unused Narcotic medications are destroyed in the medication room, with 2 nurses. LPN-K indicated 2 nurses sign off on the medication and the medication is put into a container labeled Drug Buster.LPN-K indicated that the paper work is then put into the out box in the nurses station. Surveyor preformed a narcotic medication count with LPN-E. Surveyor noted, no discrepancies identified with the narcotic medication count. On 03/10/2025, at 03:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor asked NHA-A and DON-B if the facility has had any concerns or issues with drug diversion. DON-B indicated that yes, in February around the 9th through the 11th, an incident occurred resulting in the facility initiating an Investigation. NHA-A indicated they are still in the midst of investigation the allegation. Surveyor inquired as to why the facility did not report the allegation to the State Agency. DON-B indicated the State Agency was not notified because DON-B did not know if the Narcotic medication (oxycodone) was actually missing and indicated the facility is still investigating the allegation. DON-B indicated the nurse who normally works that unit was out for about a week and upon return indicated there was a missing Narcotic medication card. On 03/11/2025, at 08:34 AM, Surveyor received the facility investigation for the missing Narcotic medication. Within the Investigation report, Surveyor noted a document which indicated the narcotic medication was last given on 02/06/2025, a card of 20 oxycodone was delivered on 01/31/2025 and was signed in to the facility. The document indicates the last oxycodone from the prior card that was deliver on 01/21/2025 contained 20 pills and was given on 02/02/2025. From 02/02/2025 there was a total of 8 oxycodone given to R12 and indicated R12 should still have 12 remaining. The card and sign out sheet were discovered missing on 02/12/2025. HR notified. Drug urine will be requested to be done on all staff that worked between time frame. All were negative. Surveyor noted written in pen 2/28/25-Sheriff notified. On 03/11/2025, at 10:55 AM, DON-B indicated to Surveyor that the facility notified Law Enforcement of the allegation after the facility Corporate [NAME] suggested to notify police on 02/28/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/11/2025, at 12:41 PM, Surveyor shared concerns with NHA-A, DON-B, Assistant Director of Nursing (ADON)-I, and Nursing Supervisor (NS)-C regarding the facility not reporting R12's missing narcotic medication to the State Agency and the delay reporting the misappropriation to law enforcement. No additional information was provided at time of write up.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50700 Based on interview and record review the facility did not ensure that 2 (R9, R12) of 3 allegations of mistreatment involving residents were investigated or thoroughly investigated timely. * R9 reported her engagement and wedding ring as missing, and the facility completed a self-report. There was no documentation of other residents on R9's unit being interviewed for missing items. R9's family reported to the facility that they suspected a newer staff member to be involved, and the facility did not submit this to the state agency nor complete an addendum to the original facility self-report. * The facility was made aware by staff that R12 had missing medications, and did not submit the allegations of potential misappropriation to the state agency. Findings include: The facility's policy titled, Abuse, Neglect, Misappropriation, Exploitation, Mistreatment dated: 10/26/2016 states under the policy: . 6. Investigation: A. The investigation is the process used to try and determine what happened. The designated facility personnel will begin the investigation immediately. If abuse injury of unknown origin suspicious injury misappropriation involuntary seclusion any violation of resident rights or exploitation, is suspected or alleged the administrator (designee) must be notified immediately. 1.) R9 was admitted to the facility on [DATE] with a diagnosis of dementia, psychotic disturbance, mood disturbance, and anxiety and obesity. R9's Quarterly Minimum Data Set (MDS) dated [DATE], documents a brief interview for mental status (BIMS) score of 13, indicating that R9 is cognitively intact. The MDS documents under section B, that R9 is understood and understands. Under section E (behavioral symptoms it documents that R9 does not exhibit any behaviors. R9's medical records nursing note, dated 12/4/2024 at: 3:03 AM, documents that a CNA informed the floor nurse of a missing wedding ring, and floor nurse in turn, updated the night shift RN supervisor of the missing ring. On 3/10/2025, at 11:06 AM, Surveyor asked Nursing Home Administrator (NHA)-A for a police report from the reported misappropriation. NHA-A indicated NHA-A made repeat attempts to receive the report through sheriff's office via phone calls and emails with no response back. NHA-A stated that NHA-A will attempt again. On 3/10/2025, at 11:27 AM, Surveyor interviewed via phone, CNA-J who stated that R9 reported missing rings at around 2:00 AM. CNA-J stated the nurse then reported to supervisor at around 2:40 AM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/2025, at 11:40 AM, Surveyor received the sheriff's report from NHA-A, The sheriff report dated, 12/5/2024 at 9:37 AM, documents: I contacted [Family member name] (Family)-L and conducted an interview via telephone. [Family member name] Family-L stated that she was told that her mother said she gave the rings to 1 of her daughters, to be cleaned. [Family member name] Family-L believes that an employee has convinced [Residents name] R9 somehow, to give them the rings. [Family member name] Family-L stated that she was told by a nurse's aide, that a different nurse's aide, had heard that the patient next door had lost a wedding ring as well. [Family member name] Family-L was unable to provide any names of any nurse's aides. [Family member name] Family-L spoke highly of the facilities staff but believed a newly hired staff member was likely involved in the disappearance of the rings. On 3/10/2025, at 1:55 PM, DON-B stated that R9 and one other resident were asked about missing items. DON-B indicated that the other resident that was questioned, claimed things are missing a lot and random items like a car but no mention of a missing ring when questioned. DON-B indicated this resident was picked because of statements from R9's family that this resident was also missing rings. DON-B stated 2 other residents were asked if everything was alright, but not about missing items. DON-B indicated not wanting to put thoughts in the resident's heads that it was unsafe at the facility. DON-B indicated having no documentation of other residents being interviewed but that second shift supervisor might have additional documentation. On 3/10/2025, at 3:33 PM, Surveyor informed NHA-A, DON-B and Assistant Director of Nursing (ADON)-I of concerns with R9's family reporting that the new hire CNA was involved in the misappropriation. DON-B indicated knowing which CNA R9's family was referring to as there was only one new hire at that time. DON-B indicated there was not a new report started or an addendum to the self-report as this CNA was already interviewed. NHA-A indicated that the new hire CNA was not interviewed again. NHA-A stated: you don't finger point someone out like that, that's jacked up. NHA-A indicated believing this was being brought up because this was a new employee. On 3/10/2025, during the end of the day meeting, Surveyor explained concern that R9's family reported concern that this new hire CNA was involved in misappropriation. Surveyor explained there was no documentation of other residents on the unit being interviewed for missing items. Surveyor explained that the facility became aware of which CNA R9's family was reporting, as there was only one new CNA hired during that time, but didn't include these findings in the reported misappropriation. On 3/10/2025, at 4:10 PM, Surveyor interviewed Registered Nurse (RN)-M who stated that RN-M is the second shift supervisor, and that RN-M did assist DON-B with R9's investigation of misappropriation. RN-M indicated that with investigations or interviews like R9's misappropriation allegation that RN-M would take notes and have documents. RN-M stated he was not the main person doing this interview, and that DON-B would have the notes or documents that pertain to this investigation. No additional information was provided. 49845 2.) Surveyor reviewed a complaint sent into the State Agency regarding allegations of narcotic/medication diversions had occurred at the facility in February 2025. Surveyor, along with a team of Surveyors, entered the facility on 03/10/2025 to execute a complaint and verification survey. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested facility Investigations from 12/2024 to current. The facility provided 2 facility Reported Investigations, Surveyor noted neither were related to medication diversion. On 03/10/2025, at 10:53 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E, on the 400 unit, regarding the procedures for Narcotic medications. LPN-E indicated all narcotic medications are kept in a [NAME] box on the medication cart. LPN-E indicated that 2 nurses will now perform the narcotic medication count in the medication room in front of the camera. Surveyor asked LPN-E if narcotic medication counts in the medication room is a newly implemented procedure. LPN-E indicated being unsure if the procedure is new, but indicated an email was sent out last month (February) indicating to ensure medication counts are done in the medication room in front of the camera. Surveyor preformed a narcotic medication count with LPN-E. Surveyor noted, no discrepancies identified with the narcotic medication count. On 03/10/2025, at 11:04 AM, Surveyor interviewed LPN-K, on the 500 unit, regarding the procedures for Narcotic medications. LPN-K indicated that Narcotic medications are kept in the [NAME] box of the medication cart. LPN-K indicated counts are down with 2 nurses and the beginning and end of each shift. LPN-K indicated that the Narcotic medication counts were not always preformed in the medication room and indicated that in February of 2025, on this unit (500 unit), there was an incident where Narcotic medications were missing. LPN-K indicated the facility was aware and after the incident, staff are now to count Narcotic medications in the medication room in front of the camera. LPN-K indicated there was training and re-education provided by the facility following the incident. LPN-K indicated destruction of unused Narcotic medications are destroyed in the medication room, with 2 nurses. LPN-K indicated 2 nurses sign off on the medication and the medication is put into a container labeled Drug Buster. Surveyor preformed a narcotic medication count with LPN-E. Surveyor noted, no discrepancies identified with the narcotic medication count. On 03/10/2025, at 03:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor asked NHA-A and DON-B if the facility has had any concerns or issues with drug diversion. DON-B indicated that yes, in February around the 9th through the 11th, an incident occurred resulting in the facility initiating an Investigation. NHA-A indicated they are still in the midst of investigating the allegation. Surveyor inquired as to why the facility did not report the allegation to the State Agency. DON-B indicated the State Agency was not notified because DON-B did not know if the Narcotic medication (oxycodone) was actually missing and indicated the facility is still investigating the allegation. DON-B indicated the nurse who normally works that unit was out for about a week and upon return indicated there was a missing Narcotic medication card. On 03/11/2025, at 08:34 AM, Surveyor received the facility investigation for the missing Narcotic medication. Within the Investigation report, Surveyor noted a document which indicated the narcotic medication was last given on 02/06/2025, a card of 20 oxycodone was delivered on 01/31/2025 and was signed in to the facility. The document indicates the last oxycodone from the prior card that was deliver on 01/21/2025 contained 20 pills and was given on 02/02/2025. From 02/02/2025 there was a total of 8 oxycodone given to R12 and indicated R12 should still have 12 remaining. The card and sign out sheet were discovered missing on 02/12/2025. Human Resources (HR) notified. Drug urine will be requested to be done on all staff that worked between time frame. All were negative. Surveyor noted written in pen 2/28/25-Sheriff notified. On 03/11/2025, at 10:55 AM, DON-B indicated to Surveyor that the facility notified Law Enforcement of the allegation after the facility Corporate [NAME] suggested to notify police on 02/28/2025. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/11/2025, at 12:41 PM, Surveyor shared concerns with NHA-A, DON-B, Assistant Director of Nursing (ADON)-I, and Nursing Supervisor (NS)-C regarding the facility not submitting R12's missing Narcotic medication Investigation to the State Agency within 5 working days. No additional information was provided at time of write up.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based in interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 (R8) of 4 residents reviewed. * On 12/4/2025 at 9:00 AM R8 did not have a comprehensive assessment completed when R8 yelled and cried out stated stated R8's foot hurt. Licensed practical nurse (LPN) assessed R8's leg instead of R8's foot and noted no pain. There was no documentation of an assessment or pain assessment completed at that time for R8. On 12/4/2025 in the evening R8 was noted to have pain in the left foot, LPN noted R8 left toes were swollen and painful to touch. An order for x-ray was obtained and R8 was noted to have a 3rd, 4th, and 5th, metatarsal (toe) fractures on the left foot. R8 was sent to the hospital for further evaluation and readmitted to the facility with a half open cast and Ace wrap to R8's left lower extremity. Findings include: The facility policy titled Change of Condition Assessment and Reporting Requirements revised February 1, 2019, documents: Purpose: 1. To identify individuals at risk for an acute change of condition (ACOC). 2. To systemically collect and document data when the resident experiences an ACOC. 3. To systemically collect and document data to monitor the resident's condition in response to treatment. 7. To ensure that any chance in condition or incident is reported in accordance with State and Federal guidelines. Procedure: Step 1- Identify individuals at risk for ACOC's. - All interdisciplinary team (IDT) members are expected to report findings that may represent and [sic] ACOC. (this includes CNA's .) Step 2- Describe and document symptoms and/or condition changes accurately and completely . When assessing a resident with signs and symptoms that may indicate an ACOC the minimum to be done includes: - Regardless of cognitive level, ask the resident how he/she is feeling or how the symptoms developed. Absence of a response should be documented. - Take vital signs. - Assess overall condition, . and function. Step 3- Document the nature, extent and severity of symptoms, abnormalities and condition changes clearly and in detail to help distinguish potential causes and consequences and to determine whether the symptoms are problematic or simply normal expected variants. - Observation, documentation and description of symptoms must be distinguished from interpretation. Complete head to toe assessment of resident (neurological, . skin, behavior, musculoskeletal, pain, .). - Imprecise descriptions of the problem or incorrect interpretation of the symptoms may lead to erroneous diagnosis and inappropriate treatment. - Document assessment on situation, background, assessment, recommendation (SBAR) form and file in the chart. Be sure to enter that an SBAR was completed in the medical record. Documentation/ Follow-up Guidelines: -Monitor progress: all staff are responsible for reporting any findings that may represent ACOC's. - Frequency of assessment must be determined by the registered nurse (RN) according to stability of condition but must be completed at least one time per shift for all residents on report for ACOC. - To facilitate communication, resident should be placed on the To Do list . for follow-up charting for 72 hours after the change. - Review all progress notes at least daily including summary of overall condition and a comparison of actual progress with expected progress as noted in the care plan. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R8 was admitted to the facility on [DATE] and has diagnoses that include Multiple Sclerosis, Dementia with behavioral disturbance, major depressive disorder, Pseudobulbar affect, right foot drop, polyneuropathy, memory deficit and severe osteopenia. R8's Quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 12, indicating that R8 has moderately impaired cognition. The MDS documents that R8 needs total assist with 1 staff member for toileting and personal hygiene, lower body dressing, putting on and off footwear, and repositioning. R8 was incontinent of bowel and bladder and wore protective briefs and required a Hoyer lift with 2 staff members for transfers. R8's pain MDS assessment documented R8 denied pain, does not receive scheduled pain medication, did not receive as needed (PRN) pain medication or other interventions for pain in the last 5 days of the assessment on 9/24/2024. R8's annual MDS dated [DATE] did not trigger a pain care area assessment (CAA). R8's pain care plan was initiated on 8/5/2021 and last reviewed/revised on 1/17/2025 with the following interventions: Problem: I (R8) may experience pain. I like to keep my pain at a minimum. I have neuropathic pain and right foot drop and utilize Gabapentin daily at bedtime to promote comfort. - I need my aides to --- be extra gentle with me; ask me if I hurt; tell the nurse if I hurt; help me get dressed; be patient with me; keep my chair comfortable; make my bed comfortable; help me to change position. - I need my nurse to --- ask me if I hurt; be patient with me; help me mover around if I need it; Help me to change position. On 12/4/2024, at 2018 (8:18 PM), in the progress notes, nursing documented R8 complained of left foot pain when up for supper. Later when CNA was going to give R8 a shower, R8 complained of left foot pain. The CNA notified nursing a that time. Nursing noted some swelling, no bruising or redness, and painful to touch. Nurse supervisor notified and new orders x-ray. R8's progress note dated 12/4/2024, at 2206 (10:06 PM) documented R8 going to hospital for further evaluation. (R8's x-ray) positive for mild fracture to left 3rd, 4th, and 5th metatarsals (toe). R8's progress note dated 12/5/2024, at 0409 (4:09 AM), documented R8 returned to facility with half open cast with ACE wrap to left lower extremity. The Facility submitted a Facility Self Report on 12/5/2024 at 3:06 PM for an injury of unknown origin for R8. The summary of incident documents: . - On December 4th, 2024, R8 was found to have a displaced fracture of the left 3rd, 4th, and 5th metatarsals. R8 first reported pain to the day shift CNA-D at approximately 0900 (9:00 AM) during cares. R8 did not report pain again until PM shift on December 4th at approximately 1600 (4:00 PM) to CNA-G and another CNA who was assisting CNA-G. R8 again reported pain at shower time that evening. LPN-H assessed and noted slight swelling to the left foot, no redness but R8 was having pain. X-rays were obtained and confirmed the fractures. R8 has sever cognitive impairment 2nd to Dementia. R8 is unable to state how this injury happened but stated R8 feels safe in the environment. - Describe the Effect: (R8) expressed pain with cares, putting on and taking off pants and socks. There are no identified witnesses. Time of injury unknown. (R8) has immobilizer in place and has not been reporting pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the staff statements that were documented: - CNA-D's statement documented: CNA-D was assigned R8 morning of incident. CNA-D was washing up and getting R8 dressed for the morning. R8 complained of bad pain in R8's foot. CNA-D covered R8 up and went to report situation to the nurse. The nurse went to check R8. - LPN-E's statement documented: LPN-E was the nurse working with R8 on 12/4/2024. LPN-E was called into R8's room for R8 complaining of leg pain. LPN-E documented after assessment (word assessment is crossed out in error with LPN-E initials) clinical data obtained, R8 no complaints of pain at this time. Range of motion (ROM) within normal limits at that time. Surveyor noted that CNA-D documented R8 had bad foot pain, but LPN-E documented looking at R8's leg. Neither statement document if it was R8's left or right foot or leg. - CNA-G's statement documented CNA-G was the assigned CNA for R8 on 12/4/2024 PM shift. CNA-G and another CNA went to get R8 up, R8 complained of foot pain so CNA-G went to get nurse. Surveyor noted that CNA-G's statement documents one time of R8 complaining of pain and getting the nurse. CNA-G statement does not indicate a time the nurse was notified. LPN-H's statement documented R8 complained of left foot pain when up for supper, then later when CNA was going to give R8 a shower R8 complained of left foot pain and toes. That is when CNA notified LPN-H. R8 had pain to the touch of foot and toes, some swelling noted, no redness or bruising noted. R8 unable to say what happened. Supervisor and medical provider notified. On 3/11/2025 at 8:40 AM, Surveyor called and left voice message with return phone number for CNA-G to call back Surveyor. Surveyor never received a return phone call from CNA-G. On 3/11/2025, at 9:07 AM, Surveyor called and left a message with return phone number for LPN-H to call back Surveyor. Surveyor never received a return phone call from LPN-H. On 3/10/2025, at 10:05 AM, Surveyor observed R8 sitting in a Broda wheelchair watching TV. R8 was wearing black Velcro tennis shoes. R8 did not recall a time when she had problems with her feet and denied pain at that time when talking with Surveyor. R8 stated she felt safe at the facility and did not have any concerns. Surveyor reviewed R8's medical record and noted there were no progress notes documenting R8's complaint of pain to the foot, no comprehensive assessment was documented, and no pain assessment completed for R8's complaint of foot pain in the morning on 12/4/2024. Surveyor noted a pain assessment completed on 12/4/2024, at 1939 (7:38 PM) and R8 was given two Tylenol 325 mg (totaling 650 mg) for verbal pain rating of 6/10 per order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525556	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	3506 Washington Rd Kenosha, WI 53144

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/2024, at 1:12 PM, Surveyor interviewed CNA-D who stated CNA-D usually gets R8 up and ready between 8:00 AM and 9:00 AM. CNA-D stated that R8 was lying in bed and CNA-D went to put R8's sock on and R8 yelled out about her foot and started crying. CNA-D stated she did not see anything wrong with R8's foot, but R8 was crying and never complains of pain. CNA-D covered R8 up and went to get LPN-E to look at R8. Surveyor asked if R8 had pain in the leg at all or was it just R8's foot, and what foot/leg did R8 complain about. CNA-D stated that it was definitely R8's foot that was the concern, but R8 complained of the opposite foot than what had fractures at that time. Surveyor confirmed with CNA-D that R8 has complaints of pain in the right foot. CNA-D stated yes and that is what was relayed to LPN-E. Surveyor asked if CNA-D was in the room when LPN-E checked on R8. CNA-D stated no CNA-D did not go with LPN-E. CNA-D went to help another resident and when was finished with that resident CNA-D asked LPN-E if R8 could get up and LPN-E stated that LPN-E did not see anything and R8 was good to continue getting ready for the day. Surveyor asked CNA-D if R8 had any more complaints of pain throughout the day. CNA-D stated R8 had no further complaints. Surveyor asked CNA-D if it was reported to the upcoming shift that R8 had complaints of pain in R8's foot. CNA-D could not recall if CNA-D passed it on in shift report if R8 had pain in the foot in the morning. On 3/11/2025, at 8:47 AM, Surveyor interviewed LPN-E who stated CNA-D came up and stated R8's leg hurt. LPN-E stated went into room pretty quickly because R8 never complains about pain. LPN-E stated LPN-E looked at R8's left leg. LPN-E stated R8 denied having pain and was not crying. LPN-E stated that LPN-E did not look at R8's foot or toes because CNA-D stated it was R8's leg. LPN-E stated R8's socks were on and did not remove them to look at R8's foot or toes. LPN-E stated that LPN-E held R8's heel and middle of foot to bed R8's leg to assess ROM and R8 did not indicate any pain at that time. Surveyor asked LPN-E what the Facility process or procedure is when a resident complains of pain or an acute change. LPN-E stated the nurse supervisor would be notified to come do an assessment on the resident and medical provider notified for further directions. Surveyor asked if the nurse supervisor was notified. LPN-E stated that LPN-E did not notify the nurse supervisor because R8 did not have complaints of pain and LPN-E did not see anything on R8's left leg. Surveyor asked LPN-E how LPN-E knew what leg to look at. LPN-E stated it must have been what CNA-D told LPN-E. Surveyor asked how often residents are assessed for pain and where is documentation located. LPN-E stated that LPN-E asks each resident at least once when LPN-E is working. LPN-E stated that LPN-E usually does not document pain unless resident indicated they have pain and then an assessment with any medication is given for pain and the reassessed if interventions worked. Surveyor asked if R8 wrote a progress note or passed on in shift report that R8 experienced pain. LPN-E stated did not write a progress note because R8 did not express having pain when LPN-E went to look at R8. LPN-E could not recall if R8's pain was passed on in shift report or if it was documented on the 24 hour board. LPN-E state in hindsight, maybe should have written something or told the nurse supervisor, but at the time R8 did not have pain. LPN-E stated that if R8 did express pain, LPN-E would have notified the nurse supervisor, and documented R8's pain and made a progress note. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/2025, at 9:19 AM, Surveyor interviewed Nursing Supervisor (NS)-C who stated nursing gather information if a resident is expressing pain such as: what happened, do ROM, ask if anybody hurt them. NS-C stated that if someone is experiencing pain it should be assessed and documented. Surveyor asked NS-C if NS-C was notified that R8 was having pain. NS-C was not notified and stated since it was an acute pain for R8, NS-C would have expected to be notified even if R8 rated no pain at the time so a full assessment could be completed. NS-C stated that it should have been documented in the progress notes and a pain rating obtained even though R8 did not stated R8 was having pain at that time. NS-C stated that the nursing staff had education about a year ago going over how to correctly chart a pain assessment. Surveyor asked how often pain assessments are completed and documented on residents. NS-C stated that residents should be asked each shift and if it is a new pain, a pain event should be documented that describes where the pain is located if an injury had occurred, and then fills out a pain assessment. NS-C could not find that that was done for R8 the morning of 12/4/2024. On 3/11/2025, at 9:47 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Assistant DON (ADON)-I and NS-C were also present during the interview. Surveyor asked what the expectation is when assessing a resident that indicated they had pain. DON-B stated that the nurse would do a pain assessment and then look at the resident's orders and see what is available or call the medical provider if necessary. Surveyor brought concern up regarding R8 not being comprehensively assessed when R8 complained of pain on 12/4/2024. NHA-A and DON-B stated that when LPN-E assessed R8, R8 indicated there was no pain. Surveyor stated that LPN-E looked at R8's left leg and did not look at R8's left foot or toes. Surveyor also stated that CNA-D originally stated that R8 was complaining of the right foot hurting and that CNA-D did tell LPN-E that R8's foot was hurting. NHA-A stated that at the time R8 did not complain of any pain, so no further assessment was needed. Surveyor stated that it was told to Surveyor that even though R8 did not complain at the time LPN-E looked at R8, it was still a change for R8 who never complained of pain and that R8's pain should have been comprehensively assessed and documented even though R8 was stating there was no pain at the time. DON-B and NHA-A stated that a new pain is not considered a change in condition and did not see concern due to R8 not indicating R8 had pain at the time. Surveyor requested a policy a procedure for assessing a resident when residents have a complaint. Surveyor shared concerns that R8 was not comprehensively assessed after CNA-D notified LPN-E that R8 was having foot pain. R8's leg was assessed instead of R8's foot. R8 complained of foot pain in the evening and an x-ray indicated R8 had fractures of the 3rd, 4th, and 5th metatarsals on R8's left foot. On 3/11/2025, at 12:08 PM, DON-B brought the policy and procedure for Change of Condition Assessment and Reporting Requirements. Surveyor reviewed and is documented above in the cite write up. On 3/11/2025, at 12:30 PM, Surveyor shared with NHA-A, DON-B, ADON-I, and NS-C that Surveyors concern that R8 was not comprehensively assessed when first indicated foot pain, that the leg was assessed rather than the foot, R8 had no documentation in progress notes or a pain assessment completed, and later in the evening on 12/4/2024 R8 complained of pain and a X-ray showed R8 had toe fractures on the left foot. No additional information was provided as to why R8 did not receive treatment and care in accordance with professional standards of practice for R8's foot pain.