STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS On 02/18/2025, with information gathered through 04/17/2025, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Brown Independent Living, located at 111 4th St in Waukesha, WI. Seven citations of noncompliance were issued. The complaint was substantiated. Census: 3	M 000		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was safe and provided a homelike environment. The front door included a dead bolt lock only, no door knob or levered door handle for opening the door. The findings are: On 02/18/2025 at approximately 10:10 A.M., Surveyor observed Resident 2 seated in a reclining chair within Resident 2's bedroom located on the first floor of the facility. Surveyor observed Resident 3 ambulating independently throughout the facility and Resident 4 on the floor covered with a blanket on the facility's first floor living room. During this observation, Caregiver E	M 276		

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
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 276	Continued From page 1 told Surveyor Resident 4 was able to ambulate independently and would need verbal cues on exiting the facility in an emergency situation. Caregiver E said Resident 3 would be able to exit the home independently. On 02/18/2025 at 11:52 A.M., Surveyor conducted an interview with Resident 2 in Resident 2's room. Surveyor observed a private bathroom and a walker located in Resident 2's room. Resident 2 told Surveyor s/he was able to ambulate independently within the room and bathroom, but if Resident 2 needed to get out of the facility s/he would need to use his/her walker. Resident 2 said his/her Parkinson's disease makes him/her feel like s/he is "drunk" and makes him/her unsteady when walking. On 02/18/2025 at 10:45 A.M., Licensee A and Surveyor observed the home's two exits from the first floor, including the front door exit. Surveyor observed the front door included a dead bolt lock and no door knob or levered door handle to open the door. Licensee A told Surveyor "that is just how doors are and how it was when the home was initially licensed."	M 276		
M 284	88.05(3)(e)1 HEATING SYSTEM REQUIREMENTS The home shall have a heating system capable of maintaining a temperature of 74 degrees F. The temperature in habitable rooms shall not be permitted to fall below 70 degrees F. during periods of occupancy, except that the home may reduce temperatures during sleeping hours to 67 degrees F. Higher or lower temperatures, for	M 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 284	Continued From page 2	M 284		

certain residents, including but not limited to residents of advanced age and residents with physical disabilities, shall be provided to the extent possible when requested by a resident.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure the temperature in habitable rooms were not permitted to fall below 70 degrees Fahrenheit (F).

The findings are:

On 02/18/2025 at approximately 10:10 A.M., Surveyor observed Resident 2 seated in a reclining chair covered with a blanket within Resident 2's bedroom located on the first floor of the facility. Surveyor observed Resident 3 ambulating independently throughout the facility and Resident 4 on the floor covered with a blanket on the facility's first floor living room. Surveyor observed the temperature of the air within the facility felt cool. Surveyor observed the facility's thermostat located in the living room read "62" degrees F. Caregiver E told Surveyor s/he thought there was a problem with the heating system and s/he had told Licensee A and Licensee's Spouse H about the issue on 02/17/2025.

On 02/18/2025 at 10:45 A.M., Licensee A and Surveyor observed the home's two exits from the first floor, including the front door exit. Surveyor observed an clear opening of approximately 1.5 inches under the front door to the outside. Licensee A told Surveyor s/he was not aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 284	Continued From page 3 an issue with the facility's heating system and was not aware the facility's internal temperature was 62 degrees F. Licensee A told Surveyor s/he usually keeps the facility's temperature at 70 degrees F. On 02/18/2025 at 11:52 A.M., Surveyor conducted an interview with Resident 2 in Resident 2's room. Resident 2 told Surveyor the facility was "pretty cold in here." On 02/18/2025 at 12:00 P.M., Surveyor observed the facility's thermostat located in the living room read "65" degrees F. On 02/18/2025 at approximately 12:23 P.M., Surveyor observed Licensee A place a cloth door draft stopper to cover the opening under the front door. Licensee A told Surveyor the cloth door draft stopper should be placed in front of the opening at all times in cold weather. On 02/18/2025 at 2:41 P.M., Surveyor observed the facility's thermostat located in the living room read "67" degrees F. According to Weather Underground daily observations, the outside maximum temperature in Waukesha on 02/18/2025 was 9 degrees F. The outside minimum temperature in Waukesha on 02/18/2025 was - 8 (negative 8) degrees F. http://www.wunderground.com.	M 284		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which	M 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 338	Continued From page 4 provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 means of exiting the facility provided unobstructed access to the outside. The findings are: On 02/18/2025 at approximately 10:10 A.M., Surveyor observed Resident 2 seated in a reclining chair within Resident 2's bedroom located on the first floor of the facility. Surveyor observed Resident 3 ambulating independently throughout the facility and Resident 4 on the floor covered with a blanket on the facility's first floor living room. During this observation, Caregiver E told Surveyor Resident 4 was able to ambulate independently and would need verbal cues on exiting the facility in an emergency situation. Caregiver E said Resident 3 would be able to exit the home independently. On 02/18/2025 at 10:45 A.M., Licensee A and Surveyor observed the home's two exits from the first floor, including the front door exit. Another exit led through an enclosed porch leading from the facility's kitchen to an exit to the outside. Surveyor observed several home furnishing items located in this enclosed porch obstructing the exit passageway to the exit door. Several boxes were located directly in front of the porch exit door, which Licensee A began to remove during this observation. Licensee A told Surveyor the exit passageway was "cluttered, looks like a fire hazard." On 02/18/2025 at 11:52 A.M., Surveyor	M 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 338	Continued From page 5 conducted an interview with Resident 2 in Resident 2's room. Surveyor observed a private bathroom and a walker located in Resident 2's room. Resident 2 told Surveyor s/he was able to ambulate independently within the room and bathroom, but if Resident 2 needed to get out of the facility s/he would need to use his/her walker. Resident 2 said his/her Parkinson's disease makes him/her feel like s/he is "drunk" and makes him/her unsteady when walking. On 02/18/2025 at approximately 12:43 P.M., Licensee A told Surveyor s/he stopped in at the facility 1 to 2 times per week. Licensee A told Surveyor s/he was not aware of the obstructed porch exit and believed a caregiver stored the items on the porch when moving a resident in or out of the facility.	M 338		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure a review of the fire safety evacuation plan was completed immediately following Resident 2's admission to the facility.	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 344	Continued From page 6 The findings are: On 02/18/2025 at 10:10 A.M., Surveyor observed Resident 2 seated in a reclining chair within Resident 2's bedroom located on the first floor of the facility. Caregiver E told Surveyor Resident 2 was admitted to the facility on 02/14/2025, which was later confirmed when Licensee A provided Surveyor with a list of residents and their dates of admission. On 02/18/2025 at 11:14 A.M., Licensee A said s/he had not completed a fire safety evacuation plan review with Resident 2 immediately upon his/her admission on 02/14/2025. Licensee A told Surveyor Resident 2 was not admitted to the facility for respite care. On 02/18/2025 at 11:23 A.M., Resident 2 told Surveyor s/he moved to this facility from a skilled nursing home related to diagnoses of Parkinson's disease. On 02/18/2025 at 11:52 A.M., Surveyor conducted an interview with Resident 2 in Resident 2's room. Surveyor observed a private bathroom and a walker located in Resident 2's room. Resident 2 told Surveyor s/he was able to ambulate independently within the room and bathroom, but if Resident 2 needed to get out of the facility s/he would need to use his/her walker. Resident 2 said s/he believed s/he would be able to take a shower on his/her own. Resident 2 said his/her Parkinson's disease makes him/her feel like s/he is "drunk" and makes him/her unsteady when walking. On 02/18/2025 at 12:43 A.M., Licensee A said s/he did not complete a review of the fire safety	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 344	Continued From page 7 evacuation plan with Resident 2 because Licensee A was "sick" the day Resident 2 came to the facility. Licensee A told Surveyor s/he would "need to do an evacuation assessment" with Resident 2 and send a copy of the completed form to Surveyor, as requested. On 02/19/2025 at 1:22 P.M., Surveyor received an email from Licensee A including Resident 2's completed "Resident Evacuation Assessment." The completed document included Licensee A's name as evaluator and completed on "02/19/25 [2025]." Cross Reference: M0384 DHS 88.06(2)(b) Service Agreement Except Respite	M 344		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure a service agreement was completed prior to Resident 2's	M 384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 384	Continued From page 8	M 384		

admission to the facility.

The findings are:

On 02/18/2025 at 10:10 A.M., Surveyor observed Resident 2 seated in a reclining chair within Resident 2's bedroom located on the first floor of the facility. Caregiver E told Surveyor Resident 2 was admitted to the facility on 02/14/2025, which was later confirmed when Licensee A provided Surveyor with a list of residents and their dates of admission.

On 02/18/2025 at 11:14 A.M., Licensee A told Surveyor Resident 2 makes decisions on his/her own behalf. Licensee A said s/he had not completed a service agreement with Resident 2 prior to or since Resident 2's admission on 02/14/2025. Licensee A told Surveyor Resident 2 was not admitted to the facility for respite care.

On 02/18/2025 at 11:23 A.M., Resident 2 told Surveyor s/he moved to this facility from a skilled nursing home related to diagnoses of Parkinson's disease.

On 02/18/2025 at 11:52 A.M., Surveyor conducted an interview with Resident 2 in Resident 2's room. Surveyor observed a private bathroom and a walker located in Resident 2's room. Resident 2 told Surveyor s/he was able to ambulate independently within the room and bathroom, but if Resident 2 needed to get out of the facility s/he would need to use his/her walker. Resident 2 said s/he believed s/he would be able to take a shower on his/her own. Resident 2 said his/her Parkinson's disease makes him/her feel like s/he is "drunk" and makes him/her unsteady when walking. Resident 2 told Surveyor the caregivers prepare his/her meals and administer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 384	Continued From page 9 his/her medications. On 02/18/2025 at 12:43 A.M., Licensee A said s/he did not have a signed service agreement with Resident 2 because Licensee A was "sick" the day Resident 2 came to the facility. Licensee A told Surveyor s/he would "get that [service agreement] to [Resident 2] to sign when [Licensee A] could print admit [service] agreement." Licensee A said s/he would send Resident 2's signed service agreement to Surveyor, as requested. On 02/19/2025 at 1:22 P.M., Surveyor received an email from Licensee A including "Here is also....[the] copy of the signature page of [Resident 2's] admission/service agreement." Licensee A did not include the entire service agreement with this email. The attached signature page included, "The agreement is effective on February 14th 2025 [02/14/2025] date of admission until TBD [to be determined]." The document was signed on "02/19/2025" and included the signatures of Resident 2 and Licensee A. On 04/16/2025 at 2:45 P.M., Surveyor received an email from Licensee A including Resident 2's entire service agreement, as initially requested. Cross Reference: M0344 DHS 88.05(4)(d)2.a. Fire Safety Evacuation Plan Review	M 384		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and	M 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 404	Continued From page 10 developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure an individual service plan was completed and developed for Resident 1 during Resident 1's stay at the facility between January 2024 and October 2024. The findings are: On 02/18/2025 at approximately 11:00 A.M. and 12:43 P.M., Licensee A told Surveyor Resident 1 had lived at the facility less than 1 year between January 2024 and October 2024. Licensee A told Surveyor Resident 1 would physically attack caregivers and would go to the hospital "a lot" related to behaviors. Licensee A said Resident 1 would self-harm, including banging Resident 1's head against the wall, and caregivers would send Resident 1 to the emergency room, as needed. Licensee A said 2 caregivers were required at the facility in order to provide medications to Resident 1 because Resident 1 would "fight" medication administration. Licensee A said 1 caregiver would calm and redirect Resident 1 while the other caregiver would administer Resident 1's medication. Licensee A said s/he gave Legal Guardian B a notice of involuntary discharge for Resident 1 near the end summer in 2024. Licensee A told Surveyor s/he did not allow Resident 1 back to the facility following Resident 1's last hospitalization at the beginning of October 2024 related to Resident 1's behaviors. Surveyor requested to review Resident 1's record including	M 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 404	Continued From page 11	M 404		

Resident 1's individual service plan [ISP]. Licensee A told Surveyor s/he no longer had Resident 1's record at the facility. Licensee A said s/he would have to leave the facility to retrieve Resident 1's record and would return within 30 minutes to 1 hour.

On 02/18/2024 at 12:23 P.M., Surveyor observed Licensee A return to the facility. Licensee A told Surveyor s/he was unable to locate Resident 1's record, as requested, and would send any ISP utilized between 08/01/2024 and 10/06/2024 for Resident 1 to Surveyor by 02/19/2025 by 2:00 P.M.

On 02/18/2025 at 4:29 P.M., Surveyor received an email from Licensee A. The email included, "Here is one copy of [Resident 1's] BSP [behavior service plan]." The email included an attached document titled "Behavior Support Plan" on Resident 1's funding agencies letter head. The BSP included the last date "updated" was "10/24/2023." This date was approximately 2 months before Resident 1 was admitted to the facility. The BSP did not include signatures of those persons involved in developing the plan. The BSP addressed the following needs and services for Resident 1:
* Diagnoses including intellectually disabled, anxiety, and post traumatic stress disorder (PTSD)
* Resident 1's food preferences and interests
* Interventions related to Resident 1's constipation, personal cares, and medication administration
* Resident 1's history of abuse and family support
* Description and interventions related to Resident 1's challenging and "dangerous target" behaviors
Resident 1's BSP did not include interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 404	Continued From page 12 related to seizure activity. On 03/06/2025 at 2:26 P.M., Surveyor conducted an interview with Resident 1's Funding Agency Nurse C and Funding Agency Case Manager D. Funding Agency Nurse C told Surveyor no ISP was ever received from or reviewed with Licensee A. Funding Agency Case Manager D told Surveyor Resident 1's seizures were controlled until s/he started having seizures prior to Resident 1's discharge from the facility on 10/06/2024. Funding Agency Care Manager D said there were concerns Resident 1 was not administered lacosamide, as prescribed. On 04/16/2025 at 12:47 P.M., Surveyor conducted an interview with Licensee A. Licensee A told Surveyor s/he usually used BSPs from the resident's funding agency, including Resident 1's, for the resident's ISP. Licensee A said s/he printed off a copy of the BSP from the resident's portal and placed in the resident's record at the facility for caregivers to review. Licensee A said s/he would look for Resident 1's ISP and send it to Surveyor. On 04/17/2025 at 10:27 A.M., Surveyor received an email from Licensee A including, "...I can't [sic] locate [Resident 1's] ISP." Cross Reference: M0582 DHS 88.10(3)(q) Medications	M 404		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 13 medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 received medications in the dosage and at the intervals prescribed by Resident 1's physician. During the months of August 2024, September 2024, and until 10/03/2024, Resident 1 was prescribed to receive a 100 milligrams (mg) tablet and a 50 mg tablet to total 150 mg of lacosamide (a scheduled narcotic seizure medication, also called Vimpat) every morning, and 100 mg of lacosamide every evening. The facility's medication administration records (MARs) included Resident 1 did not receive 150 mg of lacosamide being administered every morning, as prescribed, between 08/05/2024 and 08/14/2024. Following 08/14/2025 through 10/03/2024, the facility's MARs included documentation Resident 1 received 100 mg of the 150 mg prescribed in the morning. Licensee A was unable to provide Surveyor with documentary evidence of a discontinuance order for Resident 1's 50 mg tablet of lacosamide every morning after 08/14/2024. Resident 1 experienced increased seizure activity during September 2024 and October 2024. On 10/03/2024, Resident 1 was evaluated and treated in a hospital emergency room related to seizure activity. Resident 1's blood was checked for lacosamide level and the level was below therapeutic range. Resident 1	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 14	M 582		

received a prescription to increase Resident 1's lacosamide to 200 mg every morning and evening before Resident 1 was returned to the facility. Resident 1's pharmacy stated no lacosamide was delivered to the facility after 09/17/2024. The facility's MARs did not include documentation of any lacosamide doses of lacosamide being administered to Resident 1 after 10/03/2024, including the increased lacosamide dosage of 200 mg twice daily, as prescribed on 10/03/2024. Resident 1 was taken to the hospital on 10/06/2024 related to seizure activity and hospitalized from the emergency room on 10/07/2024. Resident 1 did not return to the facility.

The findings are:

On 10/31/2024, the department received complaint allegations including a resident had not been administered seizure medications resulting in the resident experiencing increased seizure activity and a lower than therapeutic level of the seizure medication in the resident's blood.

On 02/18/2025 at approximately 11:00 A.M. and 12:43 P.M., Licensee A told Surveyor Resident 1 had lived at the facility less than 1 year between January 2024 and October 2024. Licensee A told Surveyor Resident 1 would physically attack caregivers and would go to the hospital "a lot" related to behaviors. Licensee A said Resident 1 would self-harm, including banging Resident 1's head against the wall, and caregivers would send Resident 1 to the emergency room, as needed. Licensee A said 2 caregivers were required at the facility in order to provide medications to Resident 1 because Resident 1 would "fight" medication administration. Licensee A said 1 caregiver would calm and redirect Resident 1 while the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 15	M 582		

other caregiver would administer Resident 1's medication. Licensee A told Surveyor Resident 1's Legal Guardian B would not always provide discharge summaries or documentation of changes to the facility when Legal Guardian B would return Resident 1 to the facility following physician appointments, emergency room visits, or hospitalizations. Licensee A said the facility would receive a medication change notice from the pharmacy with any changes to Resident 1's medication prescriptions. Licensee A said s/he gave Legal Guardian B a notice of involuntary discharge for Resident 1 near the end summer in 2024. Licensee A told Surveyor s/he did not allow Resident 1 back to the facility following Resident 1's last hospitalization at the beginning of October 2024 related to Resident 1's behaviors. Licensee A told Surveyor Legal Guardian B accused the facility caregivers of stealing Resident 1's medications leading up to Resident 1's last hospitalization from the facility and would often "get mad" at caregivers. Licensee A said s/he checked to ensure caregivers "signed off" Resident 1's medications and believed Resident 1 was administered all medications as prescribed.

On 02/19/2025 at 12:42 P.M., 1:08 P.M., and 4:29 P.M., Surveyor received emails from Licensee A. The emails included hospital documentation dated prior to Resident 1's admission to the facility in January 2024. The documentation included Resident 1's diagnoses included developmental disabilities, including seizures, and agitation related to post-traumatic stress disorder (PTSD). The emails included Resident 1's funding agency behavior support plan dated 10/24/2023, prior to Resident 1's admission to the facility. Resident 1's behavior support plan included, "It is important to not skip any medications." The email included an attachment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 16	M 582		

including an email from Licensee A to Legal Guardian B, Resident 1's Funding Agency Nurse C, and Resident 1's Funding Agency Case Manager D. The attached email was dated 10/07/2024 at 8:02 A.M. and included, "Good morning team, yesterday [Resident 1] had 2 seizure[s] and was admitted to [hospital name]. [Resident 1's] health and mental behavior is changing and [s/he] is becoming much more violent towards people in the house. We [facility] strongly feel whatever is happening with [Resident 1] is way beyond what we are capable of handling. We have made the decision to not take [Resident 1] back at the house. We do not feel it is safe for [him/her] or other people in the house if [s/he] returns. [Resident 1] is well beyond [his/her] 30 days [following involuntary discharge] as well. We are doing an emergency termination per DHS 88.08 as to prevent harm to [Resident 1] or any other residents. Once again, we no longer feel it is safe for [Resident 1] or any one else in the house as [s/he] needs more care than what we can provide. We will be packing [his/her] room and storing [his/her] items for a maximum of 30 days."

On 02/19/2025 at 1:01 P.M., Surveyor received an email from Licensee A including 3 of 3 pages of Resident 1's medication administration record (MAR) for 08/05/2024 through 08/13/2024. This MAR included an order for lacosamide 100 mg tablet to be administered "by mouth in the morning and in the evening." This dose was ordered from "07/02/2024" through "12/29/2024." Caregiver G documented 5 doses of the lacosamide 100 mg and another caregiver (documentation of caregiver's initials not identified) documented 4 doses of lacosamide 100 mg out of 20 total potential doses during this time frame. This MAR included an order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 17 lacosamide 50 mg tablet to be administered "every morning with 100 mg (total 150 mg morning dose)." This dose was ordered from "06/17/2024" through "12/14/2024." Caregiver G documented 5 doses of the lacosamide 50 mg administered with the morning 100 mg tablet during this time frame. Another caregiver documented 2 doses of lacosamide 50 mg were administered in error to Resident 1 on the morning and evening on 08/16/2024 and 08/17/2024, instead of 1 dose of lacosamide 50 mg on each morning on 08/16/2024 and 08/17/2024. On 04/16/2025 at 12:47 P.M., Surveyor conducted an interview with Licensee A. Licensee A told Surveyor Caregiver G would have been working most days between 08/05/2024 and 08/13/2024 and would have been at the facility to administer both morning and evening medications prescribed for Resident 1. Licensee A said s/he believed Caregiver G only "initialed" Resident 1's MAR once during the entire day for each medication prescribed instead of documenting administration for each dose prescribed during the entire day. On 02/19/2025 at 1:02 P.M., Surveyor received an email from Licensee A including 3 of 3 pages of Resident 1's MAR for 08/14/2024 through 09/04/2024. This MAR included an order for lacosamide 100 mg tablet to be administered "by mouth in the morning and in the evening." Caregivers documented all but 2 doses of lacosamide were administered, as prescribed, during 08/05/2024 and 09/04/2025. The administration documentation for 2 consecutive morning doses on 08/19/2024 and 08/20/2024 was left blank on the MAR. This MAR did not include an order for lacosamide 50 mg tablet (a seizure medication) to be administered "every morning with 100 mg (total 150 mg morning dose)."	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 18 On 02/19/2025 at 1:03 P.M., Surveyor received an email from Licensee including 3 of 3 pages of Resident 1's MAR for 09/04/2024 through 10/03/2024. This MAR included an order for lacosamide 100 mg tablet to be administered "by mouth in the morning and in the evening." Caregivers documented all potential doses administered during this time frame. This MAR did not include an order for lacosamide 50 mg tablet (a seizure medication) to be administered "every morning with 100 mg (total 150 mg morning dose)." On 04/16/2025 at 12:47 P.M., Surveyor conducted an interview with Licensee A. Licensee A told Surveyor s/he would need to look for more documentation as to why Resident 1's lacosamide 50 mg morning dose dropped off Resident 1's MAR since around 08/14/2024. Licensee A said the facility should have seen this omission and contacted the pharmacy in the absence of a discontinuation order for lacosamide 50 mg. Licensee A said lacosamide was a medication the pharmacy had on an automatic refill and delivery until the pharmacy changed. Licensee A said after the change, the facility was told to call for certain medications to be refilled and delivered and lacosamide was one of those medications. Licensee A said the facility did not receive written practitioner medication/prescription orders and just used the medications and directions included within the MARs in lieu of orders/prescriptions. Licensee A said the facility needed to improve upon this noncompliance. Licensee A told Surveyor s/he did not send Surveyor a MAR for Resident 1 documented after 10/03/2024 as requested because s/he could not remember when Resident 1 was discharged from the facility. Licensee A told Surveyor s/he would send Resident 1's October 2024 MAR to Surveyor as soon as	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 19	M 582		

possible on 04/17/2025. Surveyor asked Licensee A to send documentation of Resident 1's seizure and behavioral activity at the facility between 08/01/2024 and Resident 1's discharge from the facility on 10/06/2024, as originally requested from Licensee A on 02/18/2025. On 04/17/2025 at 10:27 A.M., Surveyor received an email from Licensee A including, "....[Licensee A] can not located [sic] the last MARs form for the last 2 days [Resident 1] was with us..." Licensee A's email included, "...so, the dates I [Licensee A] have for [Resident 1's] seizures during the month[s] of August, September, and October are as follows[:] September 9th, October 3rd, and October 6th. When [Resident 1] would have seizures [Legal Guardian B] would be called and [Licensee A's Spouse H] made a note of it in [his/her] phone notes." The email included, "Also, the behavior support tracking does not have seizures reported on it only [his/her] behaviors."

On 03/06/2025 at 2:26 P.M., Surveyor conducted an interview with Resident 1's Funding Agency Nurse C and Funding Agency Case Manager D. Funding Agency Nurse C told Surveyor Resident 1 had a prescription to receive a total of lacosamide 150 mg every morning and 100 mg every evening since 06/17/2024. Funding Agency Case Manager D told Surveyor Resident 1's seizures were controlled until s/he started having seizures prior to Resident 1's discharge from the facility on 10/06/2024. Funding Agency Care Manager D said there were concerns Resident 1 was not administered lacosamide, as prescribed. On 03/07/2025 at 1:55 P.M., Surveyor received an email from Funding Agency Case Manager D including funding agency case manager documentation. Documentation dated 09/06/2024 at 3:17 P.M. included, "[Funding Agency Nurse C] received call from [Legal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 20	M 582		

Guardian B] with a few concerns. The documentation included, "...[Resident 1] has had an increase in seizure activity over the past month. [Legal Guardian B] reported [Resident 1] had one in day center this week. [Funding Agency Case Manager D] reached out to the [facility] to try to discuss concerns and updated on the search for a new home. They stated they would hold off on moving [Resident 1]..." and "They also understood that it will be difficult to place [Resident 1] and it may take some time." Documentation dated 09/19/2024 at 12:36 P.M. included, "[Legal Guardian B] also asked about medications being passed properly. [Funding Agency Nurse C] stated that they need to be giving meds [medications] according to doctors orders and [Licensee A's Spouse H] has stated that this is the case and that [s/he] trains [his/her] staff on this as well. [Funding Agency Nurse C] stated [s/he] will continue to educate [facility] about this." Documentation dated 09/25/2024 at 9:47 A.M. included, "[Funding Agency Nurse C] received messages from both [facility] and [Legal Guardian B]. [Resident 1] was picked up from day center and walked out. Staff reported [s/he] had a bad day and seemed off. When getting home [s/he] stated [sic] to act up and have behaviors. As the night went on the behaviors became worse. [S/he] stated [sic] yelling and throwing things in [his/her] room and tearing [his/her] pads off the walls. [S/he] also threw the recliner in [his/her] room. To which staff tried to enter to make sure [s/he] was not hurting [self] and was unable to go through the main door. As they made their way around to the kitchen enterence [sic] [Legal Guardian B] enter [sic] ([Licensee A's Spouse H] called [him/her]). [Legal Guardian B] entered the room and [Resident 1] was on floor actively seizing and foaming at mouth. Medicattion [sic] was given

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 21	M 582		

and 911 called. [Resident 1] went to ER [emergency room] and was evaluated and sent back to home. This am [morning] [Resident 1] went to day center and had another seizure."

On 04/07/2025 at 12:22 A.M., Surveyor received Resident 1's emergency room discharge summary dated 09/25/2025. The documentation included Resident 1's "reason for visit" included "Seizure" and "Injury of head, initial encounter." The documentation included, "No change in medications."
Surveyor received Resident 1's emergency room discharge summary dated 10/03/2024. The documentation included, "Your exam today was consistent with a seizure; with a known seizure disorder, [Resident 1] must take [Resident 1's] seizure medications without any breaks in the dosing schedule." The documentation included Resident 1's a blood test was conducted to check Resident 1's lacosamide level. The documentation included a change in Resident 1's lacosamide prescription including an increase to "take 1 (one) [200 mg] tablet by mouth 2 (two) times daily for 30 days." The documentation included Resident 1 received lacosamide 200 mg at 8:06 P.M. while at the hospital. On 04/07/2025 at 12:34 A.M., Surveyor received Resident 1's lacosamide blood levels as dated: 06/12/2024 "8.8 ug/ml" [one microgram per milliliter] "normal range: 5.0 - 10.0 ug/ml" and 10/03/2024 "2.1 ug/ml" "low."
On 03/07/2025 at 1:55 P.M., Surveyor received an email from Funding Agency Case Manager D including funding agency case manager documentation. Documentation dated 10/04/2025 at 9:12 A.M., included Legal Guardian B reported to Funding Agency Case Manager D s/he returned Resident 1 to the facility following Resident 1's emergency room visit on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 22	M 582		

10/03/2024. The documentation included, "[Legal Guardian B] also informed them [the facility] that [Resident 1] had received an increase in [his/her] seizure medication (Vimpat) [lacosamide], but had already received it at the hospital, so the Vimpat would need to be removed from the rest of [Resident 1's] evening meds [medications]." Surveyor received Resident 1's emergency room discharge summary dated 10/05/2024. The documentation included, "Discharge diagnosis: Agitation, UTI [urinary tract infection]." The documentation did not include any changes to Resident 1's lacosamide prescription.
On 03/07/2025 at 1:55 P.M., Surveyor received an email from Funding Agency Case Manager D including funding agency case manager documentation. Documentation dated 10/17/2024 at 11:41 A.M., included "[Funding Agency Nurse C] reached out to [Legal Guardian B] regarding medications for [Resident 1]." Documentation included, "On Thursday the 10/3 [10/03/2024] [Resident 1] went to ER where [his/her] blood was drawn and [his/her] Vimpat [lacosamide] was low at 2 ["2.1 ug/ml]. Which is not within therapeutic range. However, [Resident 1] was discharged back to the AFH [adult family home] that night. On 10/6 [10/06/2024] [Resident 1] had 2 seizures back to back that were severe and long lasting and retiurned [sic] to ER where blood was taken again and again [his/her] levels were at 2. [Resident 1] was admitted [to the hospital] at that time. [Resident 1] had a total of 5 seizures over the first week of October. When the AFH [facility] decided to emergency discharge [him/her] and not let [him/her] back, [Legal Guardian B] went to pick up all [his/her] belongings at the home. [Resident 1's] medications were given to [Legal Guardian B]. On Wed [Wednesday] the 9th, [Legal Guardian B] looked at the medications and realized that [Resident 1's] Vimpat [lacosamide]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 23	M 582		

was not in the newest pack. [Legal Guardian B] called the pharmacy to which [s/he] got a print out from the pharmacy and the pharmacy stated that the meication [sic] had not been picked up since August 30th [08/30/2024]. It is a controlled substance and is separate from the rest of the medications due to this. So it would have needed to be requested and was not by the AFH. When the medication [sic] were delivered they were signed for by a caregiver at the home but never checked to see that all meds [medications] were there. So [Resident 1] went without from what is believed to be October 1-6th [10/01/2024 through 10/06/2024]. Which would cause withdrawal symptoms/agitation and seizure acitivy [sic] due to non-therapeutic leves [sic]. A recent blood draw was taken this week and member as at a 10 and [his/her] seizure medicaition [sic] was then reduced and [s/he] has not had a seizure since being at the hospital. A level of 8 is therapeutic for the member at this time."

On 03/17/2025 at 9:19 A.M., Surveyor received an email from Funding Agency Case Manager D including investigation results of Resident 1's medication error. The documentation included, "Medication error and neglect were substantiated." The documentation included, "[Resident 1] missing [his/her] seizure medication for multiple days resulted in [Resident 1] experiencing more frequent and more severe seizure activity. This resulted in [Resident 1] being admitted to the hospital. Neglect was substantiated due to the failure of a caregiver as evidenced by their inaction to properly ensure [Resident 1] had all of [his/her] medications, especially vital seizure medications which created a significant risk/danger to [Resident 1's] mental and physical health." The documentation included, "According to the notes [Licensee A]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019738	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 24 was not aware and stated they would look into the missed medication doses." On 03/17/2025 at 12:10 P.M.,. Surveyor conducted an interview with Resident 1's Legal Guardian B. Legal Guardian B said s/he was concerned the facility did not have lacosamide, as prescribed, available at the facility to administer to Resident 1 leading up to Resident 1's hospitalization on 10/07/2024. Legal Guardian B said the facility needed to contact the pharmacy to request a refill of Resident 1's lacosamide medication, as prescribed. Legal Guardian B said s/he believed the facility did not pay attention and did not realize Resident 1's prescribed lacosamide was not available at the facility. On 03/17/2025 at 12:21 P.M., Surveyor conducted an interview with Pharmacist F. Pharmacist F told Surveyor the last noted delivery of Resident 1's lacosamide 50 mg tablets, as prescribed, to the facility was on 08/30/2024. Pharmacist F said a quantity of 30 tablets were delivered at that time. Pharmacist F told Surveyor the pharmacy packaging Resident 1's medications changed locations on 09/17/2024. Pharmacist F said after 09/17/2024, there was no delivery of Resident 1's lacosamide in any dosage to the facility. Pharmacist F said the pharmacy received no requests from the facility to inquire and/or request delivery Resident 1's lacosamide in any dosage following 09/17/2024. Pharmacist F said no medications prescribed for Resident 1 were delivered to the facility after 10/01/2024. Cross Reference: M0404 DHS 88.06(3)(a) Individual Service Plan And Assessment	M 582		