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 _____	R-C 09/10/2025

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 09/09/2025, with information gathered through 09/10/2025, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey and verification visit of statement of deficiency (SOD) 5D2Q11 at Brown Independent Living, located at 111 4th St in Waukesha, WI. Seven citations of noncompliance were issued, including 2 repeat violations of compliance. Census: 3 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{M 000}		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not obtain documentation from a physician, a registered nurse or a physician's assistant indicating	M 232		

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 _____	R-C 09/10/2025

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

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M 232	Continued From page 1 Caregiver I had been screened for illness detrimental to residents, including tuberculosis (TB) within 90 days before the start of providing services. The findings include: On 09/09/2025 at approximately 9:00 A.M., Surveyor observed Caregiver I working independently at the home with Resident 2, Resident 3, and Resident 4 present. Caregiver I told Surveyor s/he began working as a caregiver at the facility in February 2025 or March 2025 after emigrating from a different country in December 2024. On 09/09/2025 at approximately 10:15 A.M., Licensee A and Surveyor reviewed a list of caregiver names and dates of hire, as provided by Licensee A. Caregiver I's date of hire, or "start date" was documented as 07/28/2025. Caregiver I told Surveyor s/he trained at this home at the end of February 2025 for a couple of weeks, as well as at 2 other adult family homes licensed by Licensee A. Caregiver I said s/he was told s/he needed to complete training classes before s/he could start working as a caregiver and then began working at this home in July 2025. Licensee A told Surveyor Licensee A's Spouse H required Caregiver I to complete training classes before his/her official hire date. Licensee A and Surveyor reviewed Caregiver I's personnel record, as provided by Licensee A. Caregiver I's record included an incomplete document dated 07/02/2025 titled "Communicable Disease/Tuberculosis Screening Questionnaire." The documentation did not include documentation of whether or not Caregiver I was free from communicable disease, including TB. Photo #1. Caregiver I's personnel	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 232	Continued From page 2 record did not include a completed TB test nor a chest x-ray. Caregiver I said s/he went to a clinic for a physical but did not recall experiencing and/or receiving documentation of a completed communicable disease screen, completed TB test, or completed chest x-ray. Licensee A told Surveyor this questionnaire dated 07/02/2025 was the only documentation s/he had for Caregiver I regarding the required screening for illness detrimental to residents including TB.	M 232		
{M 276}	88.05(3)(a) Homelike 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. This requirement is being cited for the second time. See Statement of Deficiency (SOD) 5D2Q11, issued on 06/09/2025. The findings are: On 09/09/2025 at approximately 9:30 A.M., Caregiver I and Surveyor toured the home observing the home's environment. Surveyor observed the home's two exits from the	{M 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

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{M 276}	Continued From page 3	{M 276}		

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. Surveyor observed an clear opening of approximately 1.5 inches under the front door to the outside. These observations remained unchanged from the observations included within SOD 5D2Q11. Photo #2.

Surveyor observed a layer of clear material peeling from the top of the countertops located in the kitchen, including the countertops on either side of the stove. Caregiver I said it was difficult to keep the countertops clean following food preparation due to the peeling substance and s/he did not know why the countertops were peeling.

Surveyor observed a washing machine and dryer located in the basement of the home. Caregiver I turned on both appliances and told Surveyor both the washing machine and dryer were functional. Surveyor observed the dryer vent was pulled away from the wall and was not vented to the outside. Surveyor observed a pile of significantly soiled clothing including a latex glove, soiled plastic bags, and unidentified objects located on the floor and placed against the washing machine. Surveyor observed at least 2 blankets/comforters located directly on top of the washing machine and dryer. The areas, including the floor, surrounding the washing machine and dryer were not maintained in a clean, tidy manner. Caregiver I told Surveyor s/he did not know anything about the unattached dryer vent, the soiled pile of clothes and objects on the floor, and did not know if the blankets/comforters located on top of the appliances were soiled or clean nor to whom they belonged. Photos #3, #4, and #5.

Surveyor observed Caregiver I open a basement door leading to an enclosed room including

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	0019738	A. BUILDING: _____ B. WING _____	R-C 09/10/2025

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

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{M 276}	Continued From page 4 french doors leading to the outside parking area. This unkempt room was located directly beneath the home's kitchen and included several pieces of drywall, several rolls of insulation, soiled blankets and what appeared to be a mattress protector/pad, used buckets, and an overturned microwave directly on the unkempt, concrete floor. Surveyor observed exposed insulation on the walls, some of which was falling off and down onto the floor, and exposed insulation falling from the ceiling. Caregiver I said s/he did not know anything about this room. Photos #6 and #7. Surveyor observed the basement staircase leading between the basement and the home's first floor. Each step included a brown plastic/vinyl anti-slip material covering the central section of each step, several of which were loose and/or peeling off the step's surface causing a significant tripping hazard. Caregiver I told Surveyor Resident 3 was ambulatory and would go to the basement to wash some of his/her clothes. Photos #8 and #9. Surveyor observed loose ceiling panels on the ceiling above the basement staircase. Photos #10, #11, and #12. Surveyor observed Resident 4's bedroom including 1 window to the outside. Surveyor observed the curtain rod was bent significantly and the curtain was not fully covering the window. Caregiver I told Surveyor Resident 4 pulled down on the curtain hard enough and bent the metal curtain rod. Caregiver I said s/he did not know when it had occurred. Photo #13. On 09/09/2025 at approximately 1:25 P.M., Surveyor discussed these observations with Licensee A. Licensee A told Surveyor the front door was going to be fixed in the near future to include a door knob or levered handle and a strip to cover the gap between the bottom of the door	{M 276}		

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	0019738	A. BUILDING: _____ B. WING _____	R-C 09/10/2025

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

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{M 276}	Continued From page 5 and the floor. Licensee A told Surveyor s/he was unaware the dryer vent was not attached and vented to the outside, and s/he was unaware of the other observations. Licensee A told Surveyor the unkempt basement room including the french doors was closed off and no one went in that area, despite Caregiver I being able to open the door and enter the room. Licensee A said s/he believed it was possibly meant to be a garage at some point in the past. Licensee A said s/he would work on getting things repaired and getting the noncompliance corrected. Licensee A told Surveyor s/he was present at the home approximately twice weekly.	{M 276}		
M 298	88.05(3)(g) WINDOWS AND VENTILATION The home shall have ventilation for health and comfort. There shall be at least one window which is capable of being opened to the outside in each resident sleeping room and each common room used by residents. Windows used for ventilation shall be screened during appropriate seasons of the year. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure windows used for ventilation were screened in resident sleeping rooms and in each common room used by residents during appropriate seasons of the year. The findings include: On 09/09/2025 at approximately 9:30 A.M., Caregiver I and Surveyor toured the home observing the home's environment.	M 298		

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 _____	R-C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 298	Continued From page 6 Surveyor observed Resident 4's bedroom which included 1 window to the outside. Resident 4's window was open and did not include a screen. Caregiver I told Surveyor Resident 4's liked to have his/her bedroom window open. Photo #14. Surveyor observed the bathroom located on the top floor near Resident 3's and Resident 4's bedroom. This bathroom included 1 window to the outside and Caregiver I demonstrated the window was openable. Caregiver I said the window was sometimes opened for fresh air. Surveyor observed this window did not include a screen and did not include a window covering/curtain for privacy. Photo #15. Surveyor observed two kitchen windows did not include screens. Photo #16. The kitchen was not enclosed, the doorways leading from the kitchen to the upstairs resident bedrooms and first floor living room were open. On 09/09/2025 at approximately 1:25 P.M., Surveyor discussed these observations with Licensee A. Licensee A told Surveyor s/he did not know why the windows were without screens.	M 298		
M 326	88.05(3)(n)1 BED-CLEAN, GOOD CONDITION, PROPER SIZE A separate bed for each resident unless a couple chooses to share a bed. The bed shall be clean, in good condition and of proper size and height for the comfort of the resident. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 3 and Resident 4 were provided with and/or maintained a clean bed in	M 326		

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 _____	R-C 09/10/2025

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

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M 326	Continued From page 7	M 326		

good condition.

The findings are:

On 09/09/2025 at approximately 9:30 A.M., Caregiver I and Surveyor toured the home observing the home's environment.
Surveyor observed Resident 3's bedroom, including Resident 3's bed. Resident 3's bed included an orange colored mattress in poor condition. Resident 3's mattress did not include a mattress protector/cover nor sheets. The majority of the mattress was discolored, either extremely faded, bleached, or covered with a white colored substance. A section of the outer covering of the mattress at the foot of the bed was removed exposing its inner foam material. Photos #17, #18, and #19. Caregiver I told Surveyor s/he did not know where Resident 3's sheets were located and knew nothing about the condition of Resident 3's mattress.
Surveyor observed Resident 4's bedroom including interconnecting foam mats on the floor. Surveyor observed Resident 4's room did not include a bed with a mattress. Caregiver I told Surveyor Resident 4 did not sleep in a bed because Resident 4 did not like soft objects. Photo #13

On 09/09/2025 at approximately 1:25 P.M., Surveyor discussed these observations with Licensee A. Licensee A told Surveyor s/he did not recognize Resident 3's bed mattress and did not know how it became damaged. Licensee A said the home provides bed linens to residents and s/he did not know why there were no sheets on Resident 3's bed.
Licensee A and Surveyor reviewed a practitioner's order dated 01/29/2024 for Resident 4, as provided by Licensee A. The order included, "It is

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	0019738	A. BUILDING: _____ B. WING _____	R-C 09/10/2025

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

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M 326	Continued From page 8 okay that [Resident 4] sleeps on a mat and not a bed." Licensee A told Surveyor s/he had not submitted a waiver or exception request to the department related to this regulation regarding Resident 4 not utilizing a bed, as s/he was not aware of the process.	M 326		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 4's individual service plan was updated when Resident 4's needs/services changed. The findings include: On 09/09/2025 at approximately 9:30 A.M.,	M 424		

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 _____	R-C 09/10/2025

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

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M 424	Continued From page 9 Surveyor observed Resident 4 seated at a table located in the home's living room. Surveyor observed Resident 4 wearing an orthopedic boot on Resident 4's right foot. On 09/09/2025 at approximately 10:03 A.M., Caregiver I told Surveyor Resident 4 recently experienced a fractured toe on his/her right foot. Caregiver I said Resident 4 possibly injured his/her foot while attending his/her day program because Resident 4 returned with a limp and bruised toes. Caregiver I told Surveyor Resident 1 was seen by a practitioner on 09/05/2025 and was prescribed to wear a boot on his/her right foot. Caregiver I said Resident 4's practitioner also prescribed doxycycline, an antibiotic medication, twice daily to Resident 4 and an as needed tablet of fluconazole to take in case Resident 4 developed a yeast infection while taking doxycyline. Caregiver I opened the medication cabinet and Surveyor observed a prescription bottle labeled with Resident 4's name and a prescription including, "Doxycycline 100 mg [milligrams] caps [capsules]. Take 1 capsule by mouth twice daily for 10 days." The prescription was dated 09/05/2025 and the bottle included 9 remaining capsules. Surveyor observed a unit dosed, medication card including 1 tablet of fluconazole 150 mg (an antifungal medication often used to prophylactically treat yeast infections) labeled for Resident 4. The fluconazole prescription dated 09/05/2025 included, "Take 1 tablet by mouth daily for 2 days. Repeat in 72 hours as needed." The fluconazole prescription was a scheduled dose, not an as needed dose, and included a quantity of 2 tablets. Caregiver I told Surveyor there was 1 tablet available for Resident 4 within the medication cabinet. Caregiver I told Surveyor Resident 4 attends	M 424		

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	0019738	A. BUILDING: _____ B. WING _____	R-C 09/10/2025

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 424	Continued From page 10	M 424		

his/her day program every Monday, Tuesday, Thursday, and Friday.

On 09/09/2025 at approximately 11:00 A.M., Licensee A and Surveyor discussed Resident 4's needs and services. Licensee A told Surveyor Resident 4 might push a caregiver away when they attempt to brush Resident 4's hair, but s/he does not exhibit problematic behaviors anymore. Licensee A said Resident 4's current behaviors included picking up pieces of paper from the floor. Licensee A said Resident 4 used to throw self on the floor and has broken a couple of the home's televisions but nothing recently. Licensee A told Surveyor staff noticed Resident 4 was "walking funny" on 09/03/2025, his/her toe was "puffy", and no one knew how or when the injury occurred. Licensee A said Resident 4's Legal Representative J took Resident 4 to a practitioner to be evaluated on 09/05/2025. Licensee A told Surveyor Legal Representative J did not provide any documentation such as an after visit summary with practitioner's orders/prescriptions following the evaluation. Licensee A said s/he did not know what was wrong with Resident 4's toe/foot and did not think Resident 4 had a fracture. Licensee A told Surveyor s/he would contact Legal Representative J to request a copy of Resident 4's after visit summary/documentation and forward it to Surveyor when/if it was received. On 09/10/2025 at 11:47 A.M., Surveyor received an email from Licensee A including, "...[Resident 4's Legal Representative J] said [s/he] did not get an after care summary for [Resident 4's] foot, at least that's [sic] what [s/he] says which I'll [Licensee A] be honest I don't [sic] believe."

On 09/09/2025 at approximately 11:54 A.M., Surveyor conducted an interview with Licensee

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 _____	R-C 09/10/2025

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

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M 424	Continued From page 11	M 424		

A's Spouse (Caregiver) H and Licensee A. Caregiver H told Surveyor the caregivers were to attempt to shower Resident 4 every day because showers were often "a fight" related to Resident 4's resistance to personal cares. Caregiver H said Resident 4 was diagnosed with a fractured toe, or foot, and needed to wear a special boot. Caregiver H said the boot was kept on Resident 4's right foot at all times, except when assisted with a shower. Caregiver H said s/he assumed caregivers look at Resident 4's foot every day to check for swelling. Caregiver H said Resident 4 was s/he believed Resident 4 was prescribed doxycycline related to Resident 4's recent sinus infection and thought the medication should have "run its self out." Caregiver H told Surveyor Legal Representative J did not provide any documentation following Resident 4's practitioner evaluation so Licensee A and the caregivers did not know Resident 4's diagnoses for certain, did not have any directions as to when and for how long Resident 4 was to wear the boot, did not have any directions regarding monitoring Resident 4's foot, nor when Resident 4 would have a follow-up appointment with Resident 4's practitioner. Licensee A said the facility had not received a written practitioner's prescription/order for Resident 4's doxycycline medication nor fluconazole medication. Licensee A said caregivers were just following the directions on the prescription labels provided by the pharmacy.

On 09/10/2025 at 11:47 A.M., Surveyor received an email from Licensee A including Resident 4's documented observation notes dated between 08/01/2025 and 09/10/2025. A note dated 08/02/2025 at 7:45 A.M. included, "We were all watching tv [television] together and all of a sudden [Resident 4] stood up and threw the TV [television] on the floor. And now the TV is

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 _____	R-C 09/10/2025

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 424	Continued From page 12	M 424		

broken." A note dated 08/13/2025 included, "[Caregiver G] gave [Resident 4] [his/her] meds [medications] today at about 7:25 P.M., but then [s/he] spit them all out of [his/her] mouth." A note dated 09/01/2025 at 12:15 P.M. included, "[Resident 4] has been extremely stuffy today." A note dated 09/04/2025 at 6:30 P.M. included, "[Resident 4's Legal Representative J] said s/he will take [him/her] to urgent care tomorrow." A note dated 09/05/2025 at 10:30 P.M. included, "[Resident 4] has a boot on [his/her] foot and [Legal Representative J] said [Resident 4] has to take medication for 7 days." A note dated 09/06/2025 at 8:45 A.M. included, "Had a tussle with [Resident 4] and [his/her] boot this morning, [s/he] did not want to shower or change into clean pull up [incontinence brief] or brush [his/her] teeth. I [Caregiver H] found that if you feed [him/her] first this helps get [his/her] day started. While [s/he] at [sic] I [Caregiver H] was able to put [his/her] socks on an [sic] boot on." A note dated 09/07/2025 at 5:00 P.M. included, "I [Caregiver G] took off [his/her] boot to change [his/her] socks [his/her] toe looks good."

On 09/09/2025, Surveyor reviewed Resident 4's record, as provided by Licensee A. Resident 4 was admitted to the home on 02/19/2024.
Resident 4's most recent ISP, dated 04/22/2025, included Resident 4's diagnoses including cognitive impairment, seizure disorder, anxiety and "behavior issues."
Resident 4's ISP included, "Behavior considerations: Agitation, collects items off ground." Resident 4's ISP included, "Activities of Daily Living (ADLs): Needs assistance with bathing, dressing, toileting." Resident 4's ISP included, "Assistance with ADLs: Staff to assist with bathing 3 [times a week], cueing for dressing." Resident 4's ISP included, "Behavioral

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 _____	R-C 09/10/2025

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 424	Continued From page 13 interventions: Has a BSP [behavior support plan]." Licensee A told Surveyor the BSP was a document drafted by Resident 4's funding agency in 2022. Licensee A told Surveyor s/he did not have a current BSP for Resident 4 either developed by the home or Resident 4's funding agency. Resident 4's current ISP did not include documented updates, changes and related interventions. Resident 4's ISP did not address Resident 4's toe/foot injury, monitoring Resident 4's toe/foot injury, nor the use of Resident 4's boot. Resident 4's ISP did not address Resident 4's recent sinus issues, including any monitoring needed. Resident 4's ISP was not updated with the prescription for doxycycline medication nor the 2 day prescription for fluconazole medication, including any monitoring regarding either medication. Resident 4's ISP did not address Resident 4's issue with swallowing medication. Resident 4's ISP did not address Resident 4's behaviors related to declining to take medications, difficulties providing Resident 4 assistance with cares, attempting to assist Resident 4 with a shower daily instead of 3 times per week, nor Resident 4 damaging property such as the home's television. Resident 4's ISP did not include Resident 4's participation in day program 4 days per week. On 09/09/2025 at approximately 1:25 P.M., Licensee A told Surveyor Resident 4's ISP was not updated, as required.	M 424		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident,	M 464		

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 _____	R-C 09/10/2025

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M 464	Continued From page 14 the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not obtain a written, practitioner's order for Resident 4's medications including doxycycline, an antibiotic medication, and Resident 4's fluconazole, an antifungal medication, as required. The provider does not typically receive written, practitioner's orders for resident medications. The findings include: On 09/09/2025 at approximately 9:30 A.M., Surveyor observed Resident 4 seated at a table located in the home's living room. Surveyor observed Resident 4 wearing an orthopedic boot on Resident 4's right foot. On 09/09/2025 at approximately 10:03 A.M., Caregiver I told Surveyor Resident 4 recently experienced a fractured toe on his/her right foot. Caregiver I said Resident 4 possibly injured his/her foot while attending his/her day program because Resident 4 returned with a limp and bruised toes. Caregiver I told Surveyor Resident 1 was seen by a practitioner on 09/05/2025 and was prescribed to wear a boot on his/her right foot. Caregiver I said Resident 4's practitioner	M 464		

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 _____	R-C 09/10/2025

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M 464	Continued From page 15	M 464		

also prescribed doxycycline, an antibiotic medication, twice daily to Resident 4 and an as needed tablet of fluconazole to take in case Resident 4 developed a yeast infection while taking doxycycline. Caregiver I opened the medication cabinet and Surveyor observed a prescription bottle labeled with Resident 4's name and a prescription including, "Doxycycline 100 mg [milligrams] caps [capsules]. Take 1 capsule by mouth twice daily for 10 days. Qty [quantity] 14 [capsules]. No refills." The prescription was dated 09/05/2025 and the bottle included 9 remaining capsules. A quantity of 14 capsules delivered from the pharmacy would last for 7 days if administered twice daily, rather than 10 days as included within the pharmacy label. Photo #20. Surveyor observed a unit dosed, medication card including 1 tablet of fluconazole 150 mg (an antifungal medication often used to prophylactically treat yeast infections) labeled for Resident 4. The fluconazole prescription dated 09/05/2025 included, "Take 1 tablet by mouth daily for 2 days. Repeat in 72 hours as needed." The fluconazole prescription was a scheduled dose, not an as needed dose, and included a quantity of 2 tablets. Photos #21 and #22. Caregiver I told Surveyor there was 1 tablet available for Resident 4 within the medication cabinet.

On 09/09/2025 at approximately 11:00 A.M., Licensee A and Surveyor discussed Resident 4's needs and services. Licensee A said Resident 4's Legal Representative J took Resident 4 to a practitioner to be evaluated on 09/05/2025. Licensee A told Surveyor Legal Representative J did not provide any documentation such as an after visit summary with practitioner's orders/prescriptions following the evaluation. Licensee A told Surveyor s/he would contact

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	0019738	A. BUILDING: _____ B. WING _____	R-C 09/10/2025

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BROWN INDEPENDENT LIVING	111 4TH ST WAUKESHA, WI 53188

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M 464	Continued From page 16 Legal Representative J to request a copy of Resident 4's after visit summary/documentation and forward it to Surveyor when/if it was received. On 09/10/2025 at 11:47 A.M., Surveyor received an email from Licensee A including, "...[Resident 4's Legal Representative J] said [s/he] did not get an after care summary for [Resident 4's] foot, at least that's [sic] what [s/he] says which I'll [Licensee A] be honest I don't [sic] believe." On 09/09/2025 at approximately 11:54 A.M., Surveyor conducted an interview with Licensee A's Spouse (Caregiver) H and Licensee A. Caregiver H said Resident 4 was diagnosed with a fractured toe, or foot, and needed to wear a special boot. Caregiver H said s/he believed Resident 4 was prescribed doxycycline related to Resident 4's recent sinus infection and thought the medication should have "run its self out." Caregiver H told Surveyor Legal Representative J did not provide any documentation following Resident 4's practitioner evaluation. Licensee A said the facility had not received a written practitioner's prescription/order for Resident 4's doxycycline medication nor fluconazole medication. Licensee A said caregivers were just following the directions on the prescription labels provided by the pharmacy. Licensee A said Resident 4's practitioner and pharmacy were not contacted by the facility to verify 14 capsules of doxycycline were packaged by and received from the pharmacy and clarify whether or not Resident 4 was to be administered doxycycline twice daily for 7 days, or 10 days as documented on the pharmacy label. Resident 4's doxycycline supply would not last 10 days, if 14 capsules were administered twice daily, as prescribed. Cross Reference:	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 464	Continued From page 17 M0582 DHS 88.10(3)(q) Medication On 09/09/2025, Surveyor reviewed Resident 4's record, as provided by Licensee A. Resident 4 was admitted to the home on 02/19/2024. Resident 4's most recent ISP, dated 04/22/2025, included Resident 4's diagnoses including cognitive impairment, seizure disorder, anxiety and "behavior issues." Resident 4's medication administration record (MAR) did not include documentation of Resident 4's doxycycline 100 mg capsules to be administered to Resident 4 twice daily for 10 days, as prescribed, and it did not include Resident 4's fluconazole 150 mg tablets to be administered for 2 days, as prescribed. Surveyor reviewed Resident 4's medications included within Resident 4's electronic MAR documentation dated between 08/27/2025 and 09/09/2025. Surveyor observed the name of Resident 4's other medications (such as vitamin B), medication amount (such as 100 mg), and the times to be administered (such as 8:00 A.M.). Surveyor observed Resident 4's MAR did not include the amount/number of administration for each medication (such as 2 capsules). On 09/09/2025 at approximately 1:25 P.M., Licensee A told Surveyor Resident 4's doxycycline capsules and fluconazole tablets were labeled and dispensed on 09/05/2025 by a different pharmacy than the pharmacy typically used to supply Resident 4's medications. Licensee A said neither medication was included within Resident 4's MAR because Legal Representative G picked up the medications from the pharmacy and brought them to the home on 09/05/2025. Licensee A told Surveyor the facility did not typically receive written medication orders/prescriptions for any of the residents from	M 464		

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

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M 464	Continued From page 18 practitioner's. Licensee A told Surveyor the pharmacy typically used by all of the residents uploaded the name and dosage of each medication into each resident's electronic MAR, but did not include the amount/number of each medication. Licensee A and Surveyor observed the packaging of Resident 4's medications that were tablet or capsule form from the facility's typically used pharmacy. The medications in tablet or capsule form were packaged within individual bubble packs for specific times of the day and included a small label including the amount/number of each medication. Surveyor observed the medications were not packaged in multi-day bubble packs. Licensee A told Surveyor each bubble pack was eventually destroyed after the medication was administered so it was not possible to show how many of each medication was administered without a practitioner's order and without it being included within the electronic MAR.	M 464		
{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 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	{M 582}		

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	0019738	A. BUILDING: _____ B. WING _____	R-C 09/10/2025

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{M 582}	Continued From page 19	{M 582}		

provider did not ensure Resident 4 received medications in the dosage and at the intervals prescribed by Resident 4's practitioner.

Resident 4 was not administered at least 4 doses of doxycycline 100 mg (antibiotic medication) capsules and 1 fluconazole (antifungal medication) 150 mg tablet, as prescribed on 09/05/2025.

This requirement is being cited for the second time. See Statement of Deficiency (SOD) 5D2Q11, issued on 06/09/2025.

The findings include:

On 09/09/2025 at approximately 9:30 A.M., Surveyor observed Resident 4 seated at a table located in the home's living room. Surveyor observed Resident 4 wearing an orthopedic boot on Resident 4's right foot.

On 09/09/2025 at approximately 10:03 A.M., Caregiver I told Surveyor Resident 4 recently experienced a fractured toe on his/her right foot. Caregiver I said Resident 4 possibly injured his/her foot while attending his/her day program because Resident 4 returned with a limp and bruised toes. Caregiver I told Surveyor Resident 1 was seen by a practitioner on 09/05/2025 and was prescribed to wear a boot on his/her right foot. Caregiver I said Resident 4's practitioner also prescribed doxycycline, an antibiotic medication, twice daily to Resident 4 and an as needed tablet of fluconazole to take in case Resident 4 developed a yeast infection while taking doxycycline. Caregiver I opened the medication cabinet and Surveyor observed a prescription bottle labeled with Resident 4's name and a prescription including, "Doxycycline 100 mg

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{M 582}	Continued From page 20 [milligrams] caps [capsules]. Take 1 capsule by mouth twice daily for 10 days. Qty [quantity] 14 [capsules]. No refills." The prescription was dated 09/05/2025 and the bottle included 9 remaining capsules. A quantity of 14 capsules delivered from the pharmacy would last for 7 days if administered twice daily, rather than 10 days as included within the pharmacy label. Photo #20. Surveyor observed a unit dosed, medication card including 1 tablet of fluconazole 150 mg (an antifungal medication often used to prophylactically treat yeast infections) labeled for Resident 4. The fluconazole prescription dated 09/05/2025 included, "Take 1 tablet by mouth daily for 2 days. Repeat in 72 hours as needed." The fluconazole prescription was a scheduled dose, not an as needed dose, and included a quantity of 2 tablets. Photos #21 and #22. Caregiver I told Surveyor there was 1 tablet available for Resident 4 within the medication cabinet. On 09/09/2025 at approximately 11:00 A.M., Licensee A and Surveyor discussed Resident 4's needs and services. Licensee A told Surveyor staff noticed Resident 4 was "walking funny" on 09/03/2025, his/her toe was "puffy", and no one knew how or when the injury occurred. Licensee A said Resident 4's Legal Representative J took Resident 4 to a practitioner to be evaluated on 09/05/2025. Licensee A told Surveyor Legal Representative J did not provide any documentation such as an after visit summary with practitioner's orders/prescriptions following the evaluation. Licensee A said s/he did not know what was wrong with Resident 4's toe/foot and did not think Resident 4 had a fracture. Licensee A told Surveyor s/he would contact Legal Representative J to request a copy of Resident 4's after visit summary/documentation and	{M 582}		

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{M 582}	Continued From page 21 forward it to Surveyor when/if it was received. On 09/10/2025 at 11:47 A.M., Surveyor received an email from Licensee A including, "...[Resident 4's Legal Representative J] said [s/he] did not get an after care summary for [Resident 4's] foot, at least that's [sic] what [s/he] says which I'll [Licensee A] be honest I don't [sic] believe." On 09/09/2025 at approximately 11:54 A.M., Surveyor conducted an interview with Licensee A's Spouse (Caregiver) H and Licensee A. Caregiver H said Resident 4 was diagnosed with a fractured toe, or foot, and needed to wear a special boot. Caregiver H said s/he believed Resident 4 was prescribed doxycycline related to Resident 4's recent sinus infection and thought the medication should have "run its self out." Caregiver H told Surveyor Legal Representative J did not provide any documentation following Resident 4's practitioner evaluation so Licensee A and the caregivers did not know Resident 4's diagnoses for certain. Licensee A said the facility had not received a written practitioner's prescription/order for Resident 4's doxycycline medication nor fluconazole medication. Licensee A said caregivers were just following the directions on the prescription labels provided by the pharmacy. Licensee A said Resident 4's practitioner and pharmacy were not contacted by the facility to verify 14 capsules of doxycycline were packaged by and received from the pharmacy and clarify whether or not Resident 4 was to be administered doxycycline twice daily for 7 days, or 10 days as documented on the pharmacy label. Resident 4's doxycycline supply would not last 10 days, if 14 capsules were administered twice daily, as prescribed. On 09/10/2025 at 11:47 A.M., Surveyor received	{M 582}		

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{M 582}	Continued From page 22	{M 582}		

an email from Licensee A including Resident 4's documented observation notes dated between 08/01/2025 and 09/10/2025. A note dated 09/05/2025 at 10:30 P.M. included, "[Resident 4] has a boot on [his/her] foot and [Legal Representative J] said [Resident 4] has to take medication for 7 days." There was no documentation Resident 4 declined any doses of doxycycline capsules or fluconazole tablets, as prescribed.

On 09/09/2025, Surveyor reviewed Resident 4's record, as provided by Licensee A. Resident 4 was admitted to the home on 02/19/2024. Resident 4's most recent ISP, dated 04/22/2025, included Resident 4's diagnoses including cognitive impairment, seizure disorder, anxiety and "behavior issues."
Resident 4's medication administration record (MAR) did not include documentation of Resident 4's doxycycline 100 mg capsules to be administered to Resident 4 twice daily for 10 days, as prescribed, and it did not include Resident 4's fluconazole 150 mg tablets to be administered for 2 days, as prescribed. Resident 4 should have been administered at least 9 potential capsules of doxycycline between 09/05/2025 and the morning of 09/09/2025, which would have left 5 remaining capsules. Resident 4 should have been administered both fluconazole tablets by the end of 09/06/2025, if administered as prescribed.

On 09/09/2025 at approximately 1:25 P.M., Licensee A told Surveyor Resident 4's doxycycline capsules and fluconazole tablets were labeled and dispensed on 09/05/2025 by a different pharmacy than the pharmacy typically used to supply Resident 4's medications. Licensee A said neither medication was included

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	0019738	A. BUILDING: _____ B. WING _____	R-C 09/10/2025

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{M 582}	Continued From page 23 within Resident 4's MAR because Legal Representative G picked up the medications from the pharmacy and brought them to the home on 09/05/2025. Licensee A said s/he did not know when the caregivers began administering the medications to Resident 4, or why more of the medication remains not administered if both were started on 09/05/2025, as prescribed. Cross Reference: M0464 DHS 88.07(3)(d) Medication - Written Order	{M 582}		