STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020740	A. BUILDING: _____ B. WING _____	R-C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD ALZHEIMERS SPECIAL CARE CENTER	4065 N CALHOUD RD BROOKFIELD, WI 53005

(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
{N 000}	Initial Comments On 10/30/2025 to 11/03/2025, Surveyor conducted a complaint investigation and verification visit at Lakewood Alzheimer's Special Care Center. One deficiency was identified. All previous violations from Statement of Deficiency (SOD) E8T211, dated 07/28/2025 were substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. The complaint was unsubstantiated. Census: 46	{N 000}		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received all prescribed medication in the dosage and at intervals prescribed by a practitioner. From 10/01/2025 to 10/30/2025, Resident 1 was not administered his/her prescribed Nystatin.	N 352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 352	Continued From page 1 Findings include: On 10/30/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 11/04/2019 with a diagnosis of Alzheimer's disease Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) dated 08/03/2025 indicated: "Care staff will manage and administer medications to [Resident 1] per PCP orders. Staff will notify community RN with any changes or concerns." Surveyor reviewed Resident 1's October 2025 medication administration record (MAR). The MAR had an order listed for Nystatin with instructions to apply topically to perineal area 2 times a day until healed (rash) with a start date of 09/29/2025. Resident 1 had a PRN (as needed) order for Nystatin with the same instructions and start date. -The scheduled AM Nystatin was documented as given 10/01/2025 to 10/24/2025, and 10/26/2025 to 10/30/2025. -The scheduled PM Nystatin was documented as given 10/01/2025, 10/07/2025, 10/12/2025, 10/14/2025 to 10/16/2025, 10/21/2025, 10/23/2025 to 10/25/2025, and 10/27/2025. -The scheduled PM Nystatin was documented as "Other/not in cart/waiting on pharmacy," on the following dates: 10/02/2025, 10/06/2025, 10/09/2025, 10/11/2025, 10/13/2025, 10/26/2025, and 10/29/2025. -The scheduled PM Nystatin was missing	N 352		

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N 352	Continued From page 2 administration on the following dates: 10/03/2025, 10/04/2025, 10/08/2025, 10/10/2025, 10/17/2025 to 10/20/2025, 10/22/2025, and 10/28/2025. Resident 1's progress notes did not document any concerns related to his/her Nystatin. On 10/30/2025 at 10:40 AM, Surveyor interviewed Clinical Manager B regarding Resident 1's Nystatin. Clinical Manager B confirmed Resident 1 was prescribed a scheduled and PRN Nystatin. Clinical Manager B reported staff had just let him/her know the Nystatin was not in the med cart. Surveyor showed Clinical Manager B Resident 1's October 2025 MAR and the missing PM administrations throughout the month. On 10/30/2025 at 10:46 AM, Surveyor interviewed Clinical Manager B and Executive Director I. Surveyor shared concern for the multiple occurrences of staff documenting not in cart/waiting on pharmacy and the blank administrations of Nystatin throughout October. Both staff acknowledged an understanding of the concern. Clinical Manager B asked for additional time, so s/he could call the pharmacy and talk to staff. On 10/30/2025 at 1:22 PM, Clinical Manager B sent the Surveyor the following email: "It appears we did not have the nystatin in house, in October. We have reordered the PRN dose. I have requested the scheduled Nystatin be discontinued, as [s/he] no longer needs it twice daily and [his/her] skin is good." On 11/03/2025 at 9:38 AM, Surveyor interviewed Clinical Manager B and Executive Director I via	N 352		

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N 352	Continued From page 3 phone. Clinical Manager B reported after talking to the pharmacy and staff, Resident 1's scheduled and PRN Nystatin were never received by the pharmacy in October. Clinical Manager B stated staff were documenting as given, but did not administer Resident 1's AM or PM Nystatin. Clinical Manager B reported staff had been reeducated. Both staff acknowledged Resident 1 did not receive his/her Nystatin powder during the month of October 2025.	N 352		