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N 000	Initial Comments On 05/01/2025, with information gathered through 05/05/2025, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey of Brookdale Brookfield Capitol Drive, located at 15100 West Capitol Drive in Brookfield. Two citations of noncompliance were issued. Census: 20	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure 2 caregivers, Caregiver E and Caregiver F, were screened by a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse [RN] for clinically apparent communicable disease including tuberculosis (TB) within 90 days before the start of their employment.	N 220		

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

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N 220	Continued From page 1 The findings are: On 05/01/2025 at 10:35 A.M., Surveyor observed and spoke with Caregiver F. Caregiver F said s/he was on duty for the day shift on 05/01/2025 and also worked some night shifts at this facility. On 05/01/2025 at approximately 2:58 P.M., Surveyor requested to review Caregiver E's and Caregiver F's employee records including documentation of Caregiver E's and Caregiver F's communicable disease screen. Business Office Coordinator C provided Surveyor with Caregiver E's date of hire, 02/11/2025, and Caregiver F's date of hire, 02/28/2025, and a document for both Caregiver E and Caregiver F titled "TB [tuberculosis] Surveillance Questionnaire And Individual Risk Assessment." Caregiver E's document included Caregiver E's documented answers to questions related to TB and Caregiver E's signature on 02/10/2025. The document included a "follow-up" documentation section including whether or not Caregiver E "appears to be free of the clinical symptoms of tuberculosis" or Caregiver E "appears to present the symptoms of tuberculosis or has had an unprotected exposure to someone with tuberculosis." The form did not include any other communicable diseases, other than tuberculosis, and did not include a signature of a physician, physician assistant, clinical nurse practitioner, or a licensed RN. Caregiver F's document included Caregiver F's documented answers to questions related to TB and Caregiver F's signature on 04/23/2025. The document included a "follow-up" documentation section including whether or not Caregiver F "appears to be free of the clinical symptoms of tuberculosis" or Caregiver F "appears to present	N 220		

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N 220	Continued From page 2 the symptoms of tuberculosis or has had an unprotected exposure to someone with tuberculosis." The form did not include any other communicable diseases, other than tuberculosis, to be screened and did not include a signature of a physician, physician assistant, clinical nurse practitioner, or a licensed RN. Photo #19 and #20. On 05/01/2025 at 2:58 P.M., Business Office Coordinator C told Surveyor this was the only form the facility used for communicable disease screening and the facility did not have a RN's signature for either Caregiver E and Caregiver F because the facility RN had not been to the facility to complete the screening, yet. On 05/05/2025 at 8:38 A.M., Administrator A told Surveyor RN G normally completed the screening for caregivers and s/he had been delayed in coming to the facility to complete screening for the 'new' hires. Surveyor discussed the facility's form included screening related to TB only and caregivers were required to be screened by a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse [RN] for clinically apparent communicable disease, including TB, within 90 days before the start of their employment. Administrator A said s/he would try to get the screening completed "today."	N 220		
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	N 352		

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right to refuse medication unless the medication is court ordered.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5 received all prescribed medications in the dosage and at intervals prescribed by a practitioner.

Resident 1 did not receive rivastigmine patches (prescribed to treat mild to moderate dementia) and polyethylene glycol (prescribed to treat constipation), as prescribed.

Resident 2 and Resident 3 did not receive polyethylene glycol (prescribed to treat constipation), as prescribed.

Resident 4's did not receive lidocaine 4% patches (prescribed for pain relief), as prescribed.

Resident 5 did not receive fluticasone nasal spray (prescribed for allergies), as prescribed.

The findings include:

Example 1: Resident 1's Rivastigmine patch (topical patch; medication to treat mild to moderate dementia)

On 05/01/2025 at approximately 10:51 A.M., Surveyor conducted an interview with Health and Wellness Director/Licensed Practical Nurse (HWD) B regarding Resident 1's needs and services. HWD B told Surveyor Resident 1 had diagnoses including dementia. HWD B said Resident 1 was prescribed rivastigmine within the last 1 to 2 months related to Resident 1's

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increased resistance to cares and medication administration, and wandering throughout the facility.

On 05/01/2025 at approximately 12:28 P.M., Surveyor observed HWD B remove a clear, plastic bag containing 15 rivastigmine patches from one of 2 medication carts. The bag had an affixed pharmacy label including Resident 1's name, the medication name, the medication prescription with directions for application, the date the prescription was filled by the pharmacy, and the number of patches originally contained within the bag. The label included, "Apply 1 patch topically once a day (remove old patch before applying a new one)." The label included 30 patches were filled by the pharmacy on 03/25/2025, "1 of 1." HWD B told Surveyor this bag was the only bag of rivastigmine patches available for Resident 1 at the facility. HWD B told Surveyor Resident 1 required caregiver administration of all prescribed medications.
Photo #1
HWD told Surveyor s/he reviewed/audited the medication carts on a weekly basis.

On 05/01/2025 at approximately 12:43 P.M., HWD B and Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy filled and delivered 30 rivastigmine patches for Resident 1, as prescribed, to the facility on 02/17/2025, and another 30 rivastigmine patches for Resident 1, as prescribed, to the facility on 03/25/2025.

On 05/01/2025, Surveyor reviewed Resident 1's record as provided by HWD B. Resident 1 was admitted to the facility on 01/15/2025 with diagnoses including dementia, depression, insomnia, and anxiety. Resident 1's practitioner's

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orders for medications included an order on 02/17/2025 for rivastigmine 24 hour 4.6 milligram (mg) patch, "Apply 1 patch transdermally one time a day related to [dementia], alternate sites of application. Apply 1 patch topically once a day (remove old patch before applying new patch)."
Surveyor reviewed Resident 1's medication administration records (MARs) from 02/18/2025 through 05/01/2025. During this time frame, Resident 1's February, March, April, and May 2025 MARs included caregiver documentation Resident 1 was administered 72 of 73 potential doses, with 1 dose not administered on 04/15/2025 related to "refusal." HWD B told Surveyor s/he was not aware how Resident 1 would refuse application of the rivastigmine patch on 04/15/2025.
Based on Resident 1's rivastigmine transdermal patch prescription, a 60-day supply of 60 patches originally provided by the pharmacy, respectively on 02/17/2025 and 03/25/2025, the 15 remaining patches in the bag dated 03/25/2025, and the caregiver documentation of approximately 72 patches administered between 02/18/2025 and 05/01/2025, Resident 1 did not receive rivastigmine transdermal patch administration as prescribed.

Example 2: Resident 1 's polyethylene glycol (powdered bowel medication)

On 05/01/2025 at approximately 12:34 P.M., Surveyor observed HWD B remove one 30-daily dose container of polyethylene glycol labeled with Resident 1's name from one of 2 medication carts. The container's pharmacy label dated "01/08/25 [2025]" included the practitioner's order including, "Take 17 grams by mouth every day for constipation. Hold for loose stools." The manufacturer's label included the container

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originally included "30 once-daily doses [equaling 510 grams]." Surveyor observed approximately one third of the powdered medication remained in the container. HWD B told Surveyor Resident 1 was admitted to the facility on 01/15/2025 and this container had been filled by a different pharmacy and utilized by Resident 1 prior to Resident 1's admission to the facility and came with Resident 1 upon admission. Surveyor observed HWD B remove a different one 30-daily dose container of polyethylene glycol labeled with Resident 1's name from one of 2 medication carts. The container's pharmacy label, a pharmacy typically used by the facility, dated "01/13/25 [2025], 1 of 1" included the practitioner's order including, "Mix 17 grams (fill cap to line) in 4-8 oz [ounce] of liquid, stir well, and drink once daily for constipation (hold for loose stools)." The manufacturer's label included the container originally included "30 once-daily doses [equaling 510 grams]." Surveyor observed the container was almost full of the powdered medication. HWD B told Surveyor Resident 1 required caregiver administration of all prescribed medications. Photo #2, #3, #4, #5, #6, and #7.

On 05/01/2025 at approximately 12:43 P.M., HWD B and Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy filled and delivered 1 30 once-daily dose container for Resident 1, as prescribed, to the facility on 01/13/2025.

On 05/01/2025, Surveyor reviewed Resident 1's record as provided by HWD B. Resident 1 was admitted to the facility on 01/15/2025 with diagnoses including dementia. Resident 1's practitioner's orders included an order for polyethylene glycol with directions to "Give 17 gram[s] by mouth one time a day related to

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constipation...mix with 8 oz of fluids. Hold for loose stools." Surveyor reviewed Resident 1's MARs from 01/16/2025 through 05/01/2025. Resident 1's January 2025 MAR included documentation Resident 1 was administered 15 of 16 potential doses, with 1 dose not administered on 01/26/2025 related to "refusal." Resident 1's February 2025 MAR included documentation Resident 1 was administered 26 of 28 potential doses, with 1 dose not administered on 02/14/2025 related to "refusal" and 1 dose not administered on 02/22/2025 related to "Other / See med [medication] note." HWD B and Surveyor reviewed Resident 1's electronic caregiver documentation on HWD B's laptop including Resident 1's polyethylene glycol dose was "held" on 02/22/2025 related to "loose stools." Resident 1's March 2025 MAR included documentation Resident 1 was administered 30 of 31 potential doses, with 1 dose not administered on 03/31/2025 related to "refusal." Resident 1's April 2025 MAR included documentation Resident 1 was administered 29 of 30 potential doses, with 1 dose not administered on 04/15/2025 related to "refusal." Resident 1's May 2025 MAR included documentation Resident 1 was administered 1 of 1 potential dose of polyethylene glycol. In total, the documentation within Resident 1's MARs from 01/16/2025 through 05/01/2025 included a total of 101 administered doses equaling 1717 grams of polyethylene glycol from one available container with one third of the original 30 once-daily equaling 510 gram doses of medication remaining within the container filled by a different pharmacy and received by the facility upon Resident 1's to the facility and from one, almost full container of the original 30 once-daily equaling 510 gram doses of medication filled and delivered to the facility on or about Resident 1's

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admission to the facility. Resident 1 did not receive polyethylene glycol administration as prescribed.

Example 3: Resident 2's polyethylene glycol

On 05/01/2025 at approximately 12:15 P.M., Surveyor observed HWD B remove one 30-daily dose container of polyethylene glycol labeled with Resident 2's name from one of 2 medication carts. The container's pharmacy label dated "04/15/25 [2025] 1 of 1" included the practitioner's order including, "Mix 17 grams (fill cap to line) in 4-8 oz of liquid, stir well, and drink once daily for constipation." The manufacturer's label included the container originally included "30 once-daily doses [equaling 510 grams]." Surveyor observed the container remained sealed when HWD B removed the container's lid. HWD B told Surveyor this was the only container of polyethylene glycol for Resident 2 at the facility. HWD B told Surveyor Resident 2 required caregiver administration of all prescribed medications. Photo #8, #9, and #10.

On 05/01/2025 at approximately 12:43 P.M., HWD B and Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy filled and delivered 1 30 once-daily dose container for Resident 2, as prescribed, to the facility on 04/15/2025.

On 05/01/2025, Surveyor reviewed Resident 2's record as provided by HWD B. Resident 2 was admitted to the facility on 04/07/2025 with diagnoses including dementia. Resident 2's practitioner's orders included an order dated 04/14/2025 for polyethylene glycol with directions to "Give 1 scoop [17 grams] by mouth one time a day for constipation. Mix in 4-8 oz of fluid."

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Surveyor reviewed Resident 1's MARs from 04/15/2025 through 05/01/2025. Resident 2's April and May 2025 MARs included documentation Resident 2 was administered 17 of 17 potential doses, despite the only container delivered to the facility for Resident 2 remained sealed on 05/01/2025. Resident 2 did not receive polyethylene glycol administration as prescribed.

Example 4: Resident 3's polyethylene glycol

On 05/01/2025 at approximately 12:16 P.M., Surveyor observed HWD B remove one 30-daily dose container of polyethylene glycol labeled with Resident 3's name from one of 2 medication carts. The container's pharmacy label dated "03/27/25 [2025] 1 of 1" included the practitioner's order including, "Mix 17 grams (fill cap to line) in 4-8 oz of liquid, stir well, and drink once daily every other day." The manufacturer's label included the container originally included "30 once-daily doses [equaling 510 grams]" which should last for approximately 60 days based on Resident 3's practitioner's order. Surveyor observed the container remained sealed when HWD B removed the container's lid. HWD B told Surveyor this was the only container of polyethylene glycol for Resident 3 at the facility. HWD B told Surveyor Resident 3 required caregiver administration of all prescribed medications. Photo #11, #12, #13, and #14.

On 05/01/2025 at approximately 12:43 P.M., HWD B and Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy filled and delivered 1 30 once-daily dose container for Resident 3, and as prescribed every other day, to the facility on 03/07/2025.

On 05/01/2025, Surveyor reviewed Resident 3's

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record as provided by HWD B. Resident 3 was admitted to the facility on 10/10/2024 with diagnoses including dementia and constipation. Resident 3's practitioner's orders included an order dated 03/06/2025 for polyethylene glycol with directions to administer "17 gm [grams] po [by mouth] qod [every other day]." HWD B told Surveyor s/he did not add Resident 3's polyethylene glycol, as ordered to receive every other day, to Resident 3's MAR to start administration until 04/03/2025. HWD B told Surveyor Resident 1's practitioner discontinued Resident 3's previous order for Senna [a bowel medication] on 03/06/2025 and replaced it with the order for polyethylene glycol to be administered every other day related to Resident 3 switching to public funding. HWD B said s/he did not receive an order to hold Resident 3's order for polyethylene glycol until 04/03/2025, s/he just waited until all of Resident 3's previous Senna tablets were administered. Surveyor reviewed Resident 3's MARs from 04/03/2025 through 05/01/2025. Resident 3's April and May 2025 MARs included documentation Resident 3 was administered 15 of 15 potential doses, starting on 04/03/2025, despite the only container delivered to the facility for Resident 3 remained sealed on 05/01/2025. Resident 3 did not receive polyethylene glycol administration as prescribed.

Example 5: Resident 4's lidocaine 4 % patch (topical patch; pain medication)

On 05/01/2025 at approximately 11:15 A.M., Surveyor observed HWD B remove a package/clear bag containing 10 lidocaine 4 % transdermal patches from the medication cart. The bag had an affixed pharmacy label including Resident 4's name, the medication name, the medication prescription with directions for

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application, the date the prescription was filled by the pharmacy, and the number of patches originally contained within the bag. The label included, "Apply 1 patch topically to right hip every (12 hours on, 12 hours off)." The label included 30 patches in "1 of 1" bag were filled by the pharmacy on 12/12/2024. HWD B told Surveyor this was the only bag of lidocaine patches for Resident 4 at the facility. HWD B told Surveyor Resident 4 required caregiver administration of all prescribed medications. Photo #15

On 05/01/2025 at approximately 12:43 P.M., HWD B and Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy filled and delivered lidocaine 4 % patches, as prescribed, to the facility on 05/24/2024 and, again, on 12/12/2024. Pharmacy Staff D said both deliveries were the only deliveries of this medication for Resident 4 since May 2024 and each included 1 bag of 30 patches.

On 05/01/2025, Surveyor reviewed Resident 4's record as provided by HWD B. Resident 4 was admitted to the facility on 04/25/2024 with diagnoses including cognitive disorders and arthritis. Resident 4's practitioner's order for lidocaine 4 % dated 05/24/2024 included, "Apply to right hip topically one time a day related to arthritis...(12 hours on, 12 hours off) and remove per schedule." HWD B told Surveyor there had been no change or discontinuation of this order after 05/24/2024. Surveyor reviewed Resident 4's MARs from 12/24/2024 (last date of lidocaine 4 % patch delivery from pharmacy) through 05/01/2025 included documentation of approximately 129 applications out of 129 potential doses during that time frame.

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N 352	Continued From page 12 Based on Resident 4's lidocaine transdermal patch prescription, the delivery of a 30-day supply of 30 patches originally provided by the pharmacy on 12/24/2024, the 10 remaining patches in the bag dated 12/24/2024, and the caregiver documentation of approximately 129 patches administered between 12/24/2024 and 05/01/2025, Resident 4 did not receive lidocaine transdermal patch administration as prescribed. Example 6: Resident 5's fluticasone nasal spray (allergy medication) On 05/01/2025 at approximately 12:29 P.M., Surveyor observed HWD B remove a package/clear bag containing 1 bottle of fluticasone nasal spray from the medication cart. The bag had an affixed pharmacy label including Resident 5's name, the medication name, the medication prescription with directions for application, the date the prescription was filled by the pharmacy, and the number of bottles within the bag. The label included, "Spray once in each nostril once a day for allergies." The label included 16 grams of suspension within "1 of 1" bottle were filled by the pharmacy on 02/11/2025. HWD B told Surveyor this was the only bag/bottle of fluticasone nasal spray for Resident 5 at the facility. Surveyor observed the bottle was almost full of the liquid suspension of medication. HWD B told Surveyor Resident 5 required caregiver administration of all prescribed medications. Photo #16, #17, and #18 On 05/01/2025 at approximately 12:43 P.M., HWD B and Surveyor conducted an interview with Pharmacy Staff D. Pharmacy Staff D said the pharmacy filled and delivered 1 bottle of fluticasone nasal spray to the facility on 11/27/2023 and, again, on 02/11/2025. Pharmacy	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310345	A. BUILDING: _____ B. WING _____	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BROOKFIELD CAPITOL DRIVE	15100 W CAPITOL DR BROOKFIELD, WI 53005

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N 352	Continued From page 13 Staff D said both deliveries were the only deliveries of this medication for Resident 5 since November 2023 and each included 1 bag of 1 bottle of spray medication. Pharmacy Staff D said Resident 5's bottle of fluticasone delivered on 02/11/2025 contained approximately 60 doses per bottle, as prescribed for 1 spray per nostril per day. On 05/01/2025, Surveyor reviewed Resident 5's record as provided by HWD B. Resident 5 was admitted to the facility on 11/13/2023 with diagnoses including dementia. Resident 5's practitioner's order for fluticasone dated 02/14/2025 included, "1 spray in each nostril one time a day for allergies...one spray each nostril." HWD B said the most recent order date of 02/14/2025 was a refill order. Surveyor reviewed Resident 5's MARs from 02/15/2025 (last date of Resident 5's fluticasone delivery from pharmacy) through 05/01/2025 included documentation of 152 doses, as prescribed, out of 152 potential doses during that time frame from an almost full bottle of medication since 02/15/2025. Surveyor reviewed Resident 5's MARs from 11/1/2024 through 02/14/2025. During this time frame, the order for Resident 5's fluticasone nasal spray was "2 spray[s] in each nostril one time a day for allergies." During this time frame, Resident 5's MARs included documentation of 416 doses, as prescribed, out of 424 potential doses were administered from a bottle last delivered to the facility on 11/27/2023. The 8 doses, 2 sprays to each nostril, documented as not administered to Resident 5 on 02/18/2025 and 02/19/2025 included "Med [medication] not available, was re-ordered." Based on Resident 5's fluticasone prescriptions, the two deliveries of this medication since November 2023 as provided by the pharmacy,	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 14 the remaining amount observed in the bottle dated as delivered on 02/11/2025, and the caregiver documentation of doses administered between 11/01/2024 and 05/01/2025, Resident 5 did not receive fluticasone nasal spray administration as prescribed. On 05/01/2025 at 1:05 P.M., HWD B told Surveyor s/he would be conducting training with the caregivers responsible for administering resident medications to include powdered medications, nasal sprays, topical patches, eye drops, etc. as a result of this noncompliance. On 05/05/2025 at 8:38 A.M., Administrator A told Surveyor HWD B met with the staff on 05/02/2025 and conducted a staff meeting to discuss this noncompliance and completed training with the caregivers responsible for administering resident medications. Administrator A told Surveyor the facility's primary pharmacy conducted a scheduled, annual medication audit on 05/02/2025 and completed additional training regarding medications with the staff.	N 352		