STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018097	A. BUILDING: _____ B. WING _____	R-C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY LIVING OF BROOKFIELD LLC	460 LEANORE LANE 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
{M 000}	INITIAL COMMENTS On 10/02/2023 with information gathered through 10/04/2023, Surveyor conducted a Verification Visit and review of Self Reports at Community Living of Brookfield. Ten deficiencies were identified. Five deficiencies were repeat deficiencies from Statement of Deficiency (SOD) # Q1E311 dated 11/08/2022. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, record review and interviews, the licensee did not ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. Findings include: On 10/02/2023, with information gathered through 10/04/2023, Surveyors conducted a verification visit to Statement of Deficiency (SOD) #Q1E311, dated 11/08/2023. Ten deficiencies were identified. Five deficiencies were repeat deficiencies from SOD #Q1E311. Community Living Of Brookfield was licensed by	M 216		

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

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M 216	Continued From page 1	M 216		

the department on 08/20/2020. The facility has a capacity for 4 adults in the following client groups: physically disabled; developmentally disabled; alcohol/drug dependent; emotionally disturbed/mental illness; advanced aged; irreversible dementia/Alzheimer's; traumatic brain injury and terminally ill.

On 11/08/2022, the department conducted a complaint investigation and standard survey. The following deficiencies were identified:
88.03(5)(e)1. Significant Change to the Resident.
88.04(2)(f) Condition Which Represents Harm.
88.05(4)(d)2.b. Fire Evacuation Annual Evaluation.
88.06(2)(b) Service Agreement Except Respite.
88.06(3)(f) Review of Individual Service Plan.
88.07(1)(a) Resident Care General Requirements.
88.07(3)(a) Prescription Medications.
88.10(3)(l) Resident Rights: Safe Environment.

On 10/02/2023 with information gathered through 10/04/2023, Surveyors conducted the verification visit and review of self reports. The following deficiencies were identified:
The following deficiencies were identified:
88.04(2)(a) Responsibilities.
88.04(2)(f) Condition Which Represents Harm. This is a repeat deficiency.
88.04(2)(h) Comply With OSHA.
88.06(3)(f) Review of the Individual Service Plan. This is a repeat deficiency.
88.07(1)(a) Resident Care-General. This is a repeat deficiency.
88.07(2)(a) Services.
88.07(3)(a) Prescription Medications. This is a repeat deficiency.
88.07(3)(e) 1. Medication Record Keeping.
88.10(3)(1) Resident Rights: Safe Physical

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M 216	Continued From page 2 Environment. This is a repeat deficiency. 88.10(3)(q) Resident Rights: Medication.	M 216		
{M 230}	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, record review and staff interview, the licensee did not ensure residents of the home were safe which permitted the continuation of a condition in the home which placed the residents safety at substantial risk of harm. On 07/04/2023, the licensee learned Resident 1's medication including Oxycodone 15 MG 30 tablets was missing from the home. The narcotics were never located. Staff was re-trained on checking the medication into the home. On 08/04/2023, two individuals were able to enter the home, at gun point, and remove all stored narcotics at the provider including 4 packs of Methadone totaling 120 tablets and 3 packs of Oxycodone totaling 55 tablets. This is a repeat deficiency. See Statement of Deficiency (SOD) #Q1E311, dated 11/08/2022. Findings include: Community Living of Brookfield is a non-ambulatory home, serves 4 adults who	{M 230}		

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{M 230}	Continued From page 3	{M 230}		

maybe physically disable; developmentally disabled; alcohol/drug dependent; emotionally disturbed/mental illness; advanced aged; irreversible dementia/Alzheimer's; traumatic brain injury and terminally ill.

According to a self- report, on 07/04/2023, the licensee learned Resident 1's medication including Oxycodone 15 MG 30 tablets was missing from the home. The narcotics were never located. Staff was re-trained on checking the medication into the home.

On 08/04/2023, a person attempted to enter the home claiming to work for the pharmacy. Agency Staff H immediately called Manager A to inform Manager A of the concern. When Agency Staff H returned to the door where the person was, the individual was gone from the premises.

Shortly later, two individuals came to the home and were able to enter the home, at gun point, and remove all stored narcotics at the provider including 4 packs of Methadone totaling 120 tablets and 3 packs of Oxycodone totaling 55 tablets.

On 10/02/2023, at 9:30 AM, Surveyors entered the home to conduct the verification visit to SOD #Q1E311, dated 11/08/2022. Surveyors observed the medication cabinet was not locked. Resident 3 was seated in the dining room of the home eating breakfast. Resident 4 was ambulating around the home. Resident 1 and Resident 2 were observed in their bedrooms.

At approximately 9:50 AM, Manager A arrived at the home and locked the medication cabinet. Surveyors informed Manager A that the medication cabinet containing medications for all

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{M 230}	Continued From page 4	{M 230}		

four residents of the home was not locked. Manager A stated that over the weekend an agency staff person left the home and took the key to the cabinet with him/her. They had to break into the cabinet and lock box to access the medications. Manager A stated s/he just brought a key to the home this morning and now locked the cabinet.

Theft of medications, lost medications, and not securing medications, the licensee permitted the continuation of a condition in the home which placed the residents safety at substantial risk of harm.

A review of law enforcement reports noted that on 07/11/2023, law enforcement arrived at the home to investigate 30 tablets of Oxycodone which were noted to be missing from the home.

A review of a self report noted on 08/04/2023, law enforcement came to the home due to an armed robbery of narcotic medications. The matter is currently an ongoing investigation.

When Surveyors arrived at the home on 10/02/2023, Surveyors observed the medication cabinet was not locked and a box containing medications for Resident 1 -Methadone HCL 10 MG- 113 tablets. Oxycodone 10 MG- 33 tablets.

Medications for Resident 4- Alprazolam .5 MG- 15 tablets.

The cabinet was not secured and Resident 4 was observed ambulating in the area past the unsecured cabinet.

The cabinet contained multiple bags containing multiple medications from March 2021 which

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{M 230}	Continued From page 5 Manager A stated needed to be destroyed. Cross reference: N0426 DHS 88.07(1)(a) Resident Care General N0458 DHS 88.07(3)(a) Prescription Medications N0582 DHS 88.10(3)(q) Resident Rights: Medication	{M 230}		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on observation and interview the provider did not comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. Findings include: On 10/02/2023 at approximately 9:50 AM, Surveyors toured the facility. Surveyors observed the medication cabinet unsecured. Surveyor noticed a metal popcorn tin on the bottom shelf of the medication cabinet that contained empty medication cards and lancets in the bottom of the tin.	M 235		

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M 235	Continued From page 6 On 10/02/2023 at approximately 10:19 AM, Surveyors interviewed Manager A. Manager A stated s/he knew about the popcorn tin being used as a sharps container to dispose of used lancets. Manager A stated the pharmacy didn't send a new sharps container to the facility to use. On 10/03/2023 at approximately 10:50 AM, Licensee D stated s/he was aware the facility was using a laundry detergent container to put the sharps in, but was not aware the facility was using a popcorn tin to disposed of used lancets.	M 235		
{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, record review and staff interview, the individual service plan for 1 out of 3	{M 424}		

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{M 424}	Continued From page 7	{M 424}		

residents reviewed, was not updated.

Resident 3's was not updated following recommendations by speech therapy home care. The plan did not include specific approaches to assist with the meal and the use of Thick It to ensure safe swallowing.

This is a repeat deficiency. See Statement of Deficiency (SOD) #Q1E311, dated 11/08/2022.

Findings include:

On 10/02/2023, at approximately 9:30 AM, Surveyors toured the home. Surveyors observed Resident 3 seated in the dining room finishing breakfast. Resident 3 had a cup of coffee. The coffee was of thin liquid consistency. Resident 3 was observed taking a drink and began coughing. After several episodes of coughing, at 9:55 AM, Caregiver G placed the coffee into a small Styrofoam cup and gave it back to Resident 3. Caregiver G was observed entering and exiting the dining room while Resident 3 finished the meal.

Surveyor observed a sign on the refrigerator which specifically stated "07/25/2023- Swallowing and Feeing Guidelines for [Resident 3]. Prescribed Diet: Moderate thick liquids. 4 1/2- 5 1/2 tsp Thick It to 4 oz. General Consistency - cut small." Precautions included: "Sit upright for all oral intake, food and liquid. After eating/drinking, remain sitting for one hour before reclining. Rinse mouth after each meal. Clean teeth morning and evening. Assist with eating and drinking as needed. Avoid drinking during meals."

A review of the individual service plan dated

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{M 424}	Continued From page 8 06/15/2023 noted Resident 3 required staff assistance with meals and monitoring during the meal. The plan directed staff to be present during the duration of the meal off offer help when struggling. The plan did not address the use of the Thick It product. On 10/02/2023, at approximately 11:30 AM, Surveyor interviewed Caregiver G. Surveyor asked Caregiver G if Thick It was added to the coffee. Caregiver G stated s/he did not know the coffee could be thickened. On 10/02/2023, at approximately 11:37 AM, Surveyor interviewed Manager A regarding the ISP for Resident 3. Surveyor asked if the information was included on the ISP. Manager A stated that the therapist just recently implemented the measures in July 2023 and they had reviewed the ISP in June 2023, so they did not. On 10/02/2023, at approximately 11:30 AM, Surveyor interviewed Manager A about the guidelines and Thick It. Manager A stated s/he believed the order was a PRN (as needed) only used when Resident 3 coughed. Surveyor asked Manager A for the specific order. Manager A was not able to locate the order but stated that the medication administration record showed it was a PRN. On 10/03/2023, at 3:20 PM, Surveyor interviewed Home Care Supervisor I regarding Resident 3's use of Thick It. Home Care Supervisor I reviewed the record of Resident 3 speech therapist notes. Home Care Supervisor I stated that on 07/25/2023, the physician ordered Thick It due to Resident 3's potential for aspiration and the product needs to be used all the time with liquids.	{M 424}		

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{M 426}	88.07(1)(a) RESIDENT CARE-GENERAL REQUIREMENTS The licensee shall provide a safe, emotionally stable, homelike and humane environment for residents. This Rule is not met as evidenced by: Based on observation, record review and interviews the licensee did not provide a safe and homelike environment for 4 out of 4 residents of the home. This is a repeat deficiency. See Statement of Deficiency (SOD) #Q1E311, dated 11/08/2022. Findings include: The provider is licensed to serve up to 4 residents within the client groups of developmentally disabled, physically disabled, terminally ill, alcohol/drug dependent; irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, advanced aged, and traumatic brain injury. On 10/02/2023 at approximately 9:50 AM, Surveyors toured the facility. The following was observed on tour of the facility: 1.) Five out of 6 lightbulbs in the living room were burned out. The shades were closed, the room was observed to be very dark. 2.) One of 2 lightbulbs were burned out in the bathroom. 3.) Broken glass was observed on the sidewalk outside of the garage which appeared to be	{M 426}		

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{M 426}	Continued From page 10 consistent with a broken lightbulb. 4.) Resident 3's room had a urinal on the floor, a bottle of nystatin powder on the floor, soiled linens in a basket by the door and a soiled disposable pad in the garbage can with no liner. The room contained a strong urine like odor. 5.) Light brown matter was observed on the wall in the living room. The light switch and plate cover, in the living room contained light brown matter. 6.) A large weed was observed gowning thru the wood patio deck boards. 7.) Outside the back entrance to the home, a plastic ice cream pail contained used cigarette butts. 8.) The living room floor was very sticky. 9.) The front screen door did not shut properly. There was a bulge in the frame of the door preventing the door from freely closing and opening. 10.) Two blue chairs in the living room contained light brown stains throughout. 11.) The wall by the front entrance to the home contained multiple gouges in the dry wall which were patched but not painted to match the wall. 12.) A long extension cord hung from the television in the living room to the floor creating a potential trip hazard for Resident 4 who was observed walking about the room on 10/02/2023 from 9:50 AM to 12:15 PM.	{M 426}		

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{M 426}	Continued From page 11 13.) Resident 2's room was not homelike with minimal decorations including a television and birthday balloons. Resident 2's birthday was 08/25. Dirty linen and bedding was observed on the floor of the room at approximately 10:45 AM. The garbage can in the room contained used incontinence products in the plastic can. The can did not contain any liner. Resident 2 was observed laying on the bed without a top sheet covering a plastic overlay mattress. Surveyor observed the living room blinds were open at approximately 11:30 AM. The blinds were held open by a piece of fabric tied at the top of the rod. On 10/03/2023 at approximately 10:50 AM, Surveyor shared findings with Licensee D. Licensee D stated s/he felt they shouldn't be cited for all of these things but rather use it as a teaching moment.	{M 426}		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on observation, record review and staff interview, the licensee did not provide services as identified in the resident's individual service plan that are the licensee's responsibility.	M 436		

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Resident 2 who received a tube feeding, had a history of aspiration and was observed in bed laying flat on his/her back for the feeding.

Findings include:

On 10/02/2023, at approximately 9:30 AM, Surveyor observed Resident 2 in bed. The head of the bed was slightly under a 45 degree angle. The tube feeding was running at 60 ML. Resident 2 was positioned in the bed flat. At approximately 10:25 AM, Surveyor asked Manager A about Resident 2's position in the bed while the tube feeding was running. Manager A stated that the head of the bed should be at a 45 degree angle. Surveyor informed Manager A that Resident 2 was flat in the bed. Manager A then asked Caregiver G to get Resident 2 up from the bed. Manager A stated Resident 2 will scoot self down in the bed.

At approximately 11:37 AM, Resident 2 was observed sitting upright in the wheelchair in the living room. At approximately 12:20 PM, Resident 2 was assisted back to bed. Surveyor observed Resident 2 laying flat on his/her back. Feet touched the foot board of the bed.

A review of Resident 2's individual service plan dated 09/18/2023 noted staff are to get Resident 2 out of bed at 8:00 AM and begin feeding as ordered. Staff should monitor for choking/vomiting during/after feedings and report to lead. Staff should ensure a 45 degree angle while receiving the tube feeding in the bed or in the wheelchair. Staff must keep Resident 2 up for 30 minutes after the completion of feeding. Choking/getting full quickly is common, so staff must adjust the flow of feed to medium to prevent

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M 436	Continued From page 13 choking/getting full fast. On 10/04/2023, at 9:00 AM, Surveyor interviewed RN Case Manager J regarding Resident 2. RN Case Manager J stated Resident 2 should be positioned in bed at a 45 degree angle due to risk for aspiration. RN Case Manager J stated s/he was never told Resident 2 slides down in bed, and stated Resident 2 did have mobility to slide down in the bed. RN Case Manager J stated Resident 2 does need to be positioned appropriately due to safety. On 10/04/2023, at 9:30 AM, Surveyor interviewed Case Manager K regarding Resident 2. Case Manager K stated months ago, Resident 2 did aspirate due to being flat on the back. Case Manager K stated s/he had reminded staff a number of times to ensure Resident 2 is positioned correctly.	M 436		
{M 458}	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by:	{M 458}		

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{M 458}	Continued From page 14 Based on observation and staff interviews, the provider did not ensure every prescription medication was stored securely. This is a repeat deficiency see Statement of Deficiency (SOD) # Q1E311 dated 11/08/2022. Findings include: On 10/02/2023, at 9:30 AM, Surveyors entered the facility to conduct a verification visit and review of 2 self reports related to missing and or stolen medication. Surveyors observed an unsecured medication cabinet in the home and began to look at the medications. Caregiver G removed the bag from Surveyors hand and stated the Surveyor needed to wait for the manager. At approximately 9:50 AM, Manager A arrived. The medication cabinet was not secured/locked. Inside the cabinet was a plastic box. The lock mechanism cut off. Stored inside the cabinet were shelves containing 4 plastic bins. Inside the bins were medication strips. The medication strip for Resident 1 contained a 8 day supply of the medication from 10/02/2023 to 10/09/2023 including Gabapentin 600 MG; Paroxetine HCL 40 MG; Quetiapine Fumarate 200 MG; Rozerem 8 MG; Buspirone HCL 15 MG; Mirtazapine 15 MG. Stored in a plastic box was the following: Resident 1 Methadone HCL 10 MG 8 tablets remaining on one card. Ten tablets on a second card. Twenty-eight tablets on a 3rd card. Thirty tablets on a 4th card. Thirty tablets on a 5th card. Twelve tablets on a 6th card.	{M 458}		

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{M 458}	Continued From page 15	{M 458}		

Zolipdem Tartrate 10 MG- 4 tablets.
A total of 33 tablets of Oxycodone 10 MG tablets.

Resident 4
Alprazolam .5 MG 15 tablets on one card.
Twenty eight tablets on a second card.

Stored on the bottom of the cabinet were multiple plastic bags containing a resident medications not consumed. Manager A stated those medications needed to be destroyed. Surveyors looked through the bags and for Resident 1 dating 04/29/2023; 04/30/2023; 05/05/2023; 05/06/2023; 05/07/2023; 05/08/2023; 05/26/2023; 06/08/2023; 06/28/2023; . Linzess 145 MCG 30 capsules in a container. Medications included Paroxetine HCL 40 MG; Buspirone HCL 10 MG; Amoxicillin-clavulante 875-125 MG; Gabapentin 600 MG; Clonidine HCL .01 MG for opioid withdrawal; Pramipexole DI-HCL 0.25 MG; prazosin 2mg and Quetiapine. Rozerem 8 MG; Topiramate 50 MG.

Resident 2 dated 05/15/2023 and including Famotidine 40 MG; Metformin HCL 1000 MG; Risperidone 2 MG; Carbidopa/Levodopa 25 MG morning and evening dosages.

Resident 3 dated 07/18/2023 Doxycycline Monohydrate 100 MG.

Resident 4's medication dated 11/03/2021 thru 06/25/2022 including Quetiapine 50 MG, Sertraline 25 MG, Aspirin 81 MG, and Omeprazole 40 MG.

Resident 5 medication dated 03/17/2021 including Eliquis 5 MG; Pramipexole 1.5 MG and lactobacillus 1 million cel. Rytary Cap 48.75 MG; 03/18/2023 Rytary Cap 48.75 MG; Ferrous

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{M 458}	Continued From page 16 Sulfate 325 MG; Pantoprazole DR 30 MG; Midodrine HCL 5 MG. There was also a Ziploc bag that Surveyors did not open because it contained loose pills that were not in packaging. On the shelf where the medications were located, (bottom shelf of the medication cabinet) There was three plastic grocery bags full of medications, some loose medications packets, and a Ziploc bag containing packaged and unpackaged medications. On the bottom shelf there was also a pop corn tin can that had empty medication cards in it and used lancets. On 10/02/2023 at approximately 10:43 AM, Surveyors interviewed Manager A. Manager A stated the reason the medications were still sitting there was facility policy is to have 2 people for med destruction and the facility typically only has one staff on at a time. Manager A stated s/he was aware that the medications needed to be destroyed. Cross Reference: N0216 DHS 88.04(2)(a) Responsibilities N0230 DHS 88.04(2)(f) Condition which represents risk of harm	{M 458}		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication	M 466		

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and errors and omissions. The medication controlled by the licensee shall be kept in a locked place.

This Rule is not met as evidenced by:
Based on record review and staff interview, the licensee did not keep a record of all prescription medications controlled, dispensed or administered by the licensee which showed the name of the medication, the date and time the resident took the medication and who administered the medication.

Findings include:

On 10/02/2023, Surveyor asked to review Resident 1's record. Manager A explained that all the records are now electronic. Surveyor asked Manager A to provide Resident 1's current physician orders and the medication administration record for the months of July, August, September and October 2023. A review of Resident 1's record noted Resident 1 had physician orders including the following:

Buspirone HCL 10 MG one tablet three times daily. Order dated 07/05/2023.
Gabapentin 600 MG 2 tablets three times per day. Order dated 01/25/2022.
Mirtazapine 15 MG one tablet by mouth in the morning. Order dated 05/30/2023.
Omeprazole 40 MG one capsule in the morning. Order dated 04/25/2023.
Oxycodone HCL 10 MG one tablet by mouth at 2 PM. Order dated 02/21/2022. Then re-ordered 06/22/2023.
Oxycodone HCL 15 MG one table two times per day by mouth. Order dated 02/21/2021 and

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M 466	Continued From page 18 re-ordered 06/26/2023. Paroxetine HCL 20 MG one tablet by mouth at bedtime with 40 MG to equal 60 MG. Order dated 04/25/2023. Quetiapine Fumarate 200 MG one tablet at bed time. Order dated 06/01/2023. Rozerem 8 MG one tablet at bedtime. Order dated 06/03/2023. Methadone HCL 10 MG take two tablets four times per day. Order dated 01/09/2023. Movantik 25 MG one tablet in morning every 72 hours. Ordered on 07/29/2023. According to the medication administration for the month of September 2023, the record contained a number of days when medications were not signed out as administered such as: 09/02/2023 to 09/08/2023- all medications were not signed out as given, refused or sent with the resident. From 09/04/2023 to 09/08/2023 each area on the medication administration record contained the initials "WF." The "WF" did not indentify any code or abbreviation as to whether or not it was refused, not available, or what "WF" was the abbreviation for. 09/14/2023-Methadone HCL 10 MG at 6 AM- the record did not identify if the medication was administered. 09/14 and 09/15/2023- Methadone HCL 10 MG at 10 AM- the record did not identify if the medication was administered. 09/17/2023- Gabapentin 600 MG- two tablets at 8 PM- the record did not identify if the medication was administered. 09/17/2023-Gabapentin 600 MG- two tablets at 4 PM- the record did not identify if the medication was administered. 09/17/2023-Paroxetine HCL 40 MG at bedtime- the record did not identify if the medication was administered.	M 466		

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M 466	Continued From page 19 09/17/2023-Quetiapine Fumarate 200 MG one tablet at bed time - the record did not identify if the medication was administered. 09/17/2023-Rozerem 8 MG one tablet at bedtime- the record did not identify if the medication was administered. 09/17/2023- Buspirone HCL 10 MG at bedtime- the record did not identify if the medication was administered. 09/17/2023-Buspirone HCL 10 MG at 4 PM- the record did not identify if the medication was administered. 09/17/2023- Oxycodone HCL 10 MG at 8 PM- the record did not identify if the medication was administered. 09/17/2023 and 09/18/2023- Methadone HCL 10 MG 10 PM- the record did not identify if the medication was administered. 09/23-09/25/2023 all scheduled medications were left blank or contained initial "WF". On 10/04/2023, at 9:56 AM, Surveyor interviewed Manager A regarding the medication administration record for Resident 1. Manager A explained that for some days, Resident 1 was not in the building. Manager A stated the areas on the medication administration record containing initials "WF" s/he had no idea what that was the abbreviation for. Some areas on the record contained a small triangle in the upper left corner. Manager A stated that meant the medication was "prepped." Surveyor asked Manager A if each date on the medication administration record should contain initials or an abbreviation as to why the med was not given. Manager A stated yes. The medication administration record identify why it was not given or be initialed as given for each medication pass. Manager A stated sometimes, the agency staff member administering the medications may not	M 466		

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M 466	Continued From page 20 understand how to document the administration. Sometimes, when Resident 1 goes out with family, staff should document the medications were sent with the resident.	M 466		
{M 570}	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the home was a safe environment and that residents were safeguarded from environmental hazards. The kitchen faucet exceeded 120° Fahrenheit (F). This is a recite from Statement of Deficiency # Q1E311 dated 11/08/2022. Findings include: The provider is licensed to serve up to 4 residents within the client groups of developmentally disabled, physically disabled, terminally ill, alcohol/drug dependent; irreversible dementia/Alzheimer's, emotionally	{M 570}		

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{M 570}	Continued From page 21 disturbed/mental illness, advanced aged, and traumatic brain injury. At approximately 10:15 AM, Surveyor tested the water temperature of the faucet in the main floor kitchen. The water temperature reached 127.2° F. According to the Wisconsin Department of Health Services, "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017). On 10/03/2023 at approximately 10:50 AM, Surveyors discussed findings with Licensee D. Licensee D stated they have been taking water temperatures daily and have been monitoring the water temperatures since the last survey. Licensee D then stated it could be because the hot water had not been used and the water was hotter coming out in the morning.	{M 570}		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the	M 582		

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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 record review and interviews, Resident 1 did not receive all prescribed medications in the dosage and at the intervals prescribed by Resident 1's physician.

Findings include:

On 10/02/2023, Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 08/13/2021 with a diagnoses including opioid dependence, major depression, anxiety disorder and complex regional pain syndrome I, unspecified.

Resident 1 had physician orders which included the following:
Buspirone HCL 10 MG one tablet three times daily. Order dated 07/05/2023.
Gabapentin 600 MG 2 tablets three times per day. Order dated 01/25/2022.
Mirtazapine 15 MG one tablet by mouth in the morning. Order dated 05/30/2023.
Omeprazole 40 MG one capsule in the morning. Order dated 04/25/2023.
Oxycodone HCL 10 MG one tablet by mouth at 2 PM. Order dated 02/21/2022. Then re-ordered 06/22/2023.
Oxycodone HCL 15 MG one table two times per day by mouth. Order dated 02/21/2021 and re-ordered 06/26/2023.
Paroxetine HCL 20 MG one tablet by mouth at

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bedtime with 40 MG to equal 60 MG. Order dated 04/25/2023.
Quetiapine Fumarate 200 MG one tablet at bed time. Order dated 06/01/2023.
Rozerem 8 MG one tablet at bedtime. Order dated 06/03/2023.
Methadone HCL 10 MG take two tablets four times per day. Order dated 01/09/2023.
Movantik 25 MG one tablet in morning every 72 hours. Ordered on 07/29/2023.

According to the medication administration record for the month of July 2023, Resident 1 did not receive Oxycodone 15 MG at 8 PM on 07/02/2023; 07/03; 07/04; 07/05; 07/06; and 07/08/2023.
Oxycodone 15 MG at 8 AM on 07/03; 07/04; 07/05; 07/06; and 07/08/2023.

On 10/02/2023 at 11:30 AM, Surveyors interviewed Manager A regarding the medication administration for Resident 1 on 07/02/2023 to 07/09/2023. Manager A explained that on or about 07/04/2023, they learned the delivery of the medication was not received by staff appropriately and the entire supply of Oxycodone was missing following the delivery. Manager A stated they did call law enforcement and filed a report.

On 10/03/2023, at 3:49 PM, Surveyor interviewed Pharmacy Tech L regarding the missing medication. Pharmacy Tech L confirmed that the Oxycodone HCL 15 MG was delivered to the provider on 06/29/2023 and signed by Caregiver M. The delivery included 30 tablets of Oxycodone HCL 15 MG. Pharmacy Tech L stated they were not able to replace the medication due to it being a controlled substance and they needed a law enforcement report from

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the provider which they never received.

On 10/03/2023, at 5:03 PM, Surveyor interviewed Resident 1 regarding the medication. Resident 1 stated that in July and August and September, Resident 1 became ill due to not receiving the prescribed medication. Resident 1 stated that each time it was one to two weeks without receiving medication.

Surveyor reviewed the medication administration for the month of August 2023. The following was documented:
08/04/2023-was not documented as administered.
Paroxetine HCL 20 MG one tablet by mouth at bedtime with 40 MG to equal 60 MG
Quetiapine Fumarate 200 MG one tablet at bed time.
Rozerem 8 MG one tablet at bedtime.
Methadone HCL 10 MG take two tablets four times per day. (4 PM, 10 PM).
Buspirone HCL 10 MG at 4 PM and 8 PM.
Oxycodone 10 MG at 8 PM. Also not administered on 08/05/2023 at 8 AM and 2 PM).

On 10/02/2023 at 11:30 AM, Surveyors interviewed Manager A regarding the medication administration for Resident 1 on 08/04/2023. Manager A explained that on 08/04/2023, the provider had an armed robbery of the house narcotics. Manager A stated law enforcement was involved and there is currently an open investigation.

Surveyor interviewed Manager A regarding the self report of the incident/investigation. Manager A stated based on the description from Caregiver H who was on duty during the robbery, they believe it could be Former Caregiver E and

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Former Caregiver F were involved. Caregiver H described the two individuals to law enforcement and they were investigated by law enforcement however, there is an open investigation at this time and Former Caregiver E and Former Caregiver F have not been formally charged.

Manager A stated they were able to replace some but not all of the medications taken in the robbery. Manger A stated they had to obtain different prescriptions from the physician for the Oxycodone and Methadone.

On 10/03/2023, at 3:49 PM, Surveyor interviewed Pharmacy Tech L regarding the missing medication. Pharmacy Tech L confirmed that the Oxycodone HCL 10 MG was delivered to the provider on 07/24/2023. The delivery included 88 tablets of Oxycodone HCL 10 MG. On 08/01/2023, 120 tablets of Methadone was delivered to the provider for Resident 1. Pharmacy Tech L stated they were not able to replace the medication due to it being a controlled substance and they needed a law enforcement report from the provider which they never received.

On 10/03/2023, at 4:08 PM, Surveyor interviewed Case Manager N regarding the medications and incidents on 07/04/2023 and 08/04/2023. Case Manager N stated they were not notified of the missing medication on 07/04/2023. They learned about the incident on or about 08/05/2023 when the armed robbery occurred. Case Manager N stated they were concerned as Resident 1 did not get all medications in July, August and September 2023. Case Manager N stated Resident 1 did become ill as a result.

On 10/03/2023, at 5:03 PM, Surveyor interviewed

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Resident 1 regarding the medication. Resident 1 stated that in July and August and September, Resident 1 became ill due to not receiving the prescribed medication. Resident 1 stated that each time it was one to two weeks without receiving medication.

Surveyor reviewed Resident 1's medication administration record for the month of September 2023. The record noted Resident 1 did not receive medications on 09/03/2023 to 09/08/2023. Medications including the following:
-Buspirone HCL 10 MG one tablet three times daily.
-Gabapentin 600 MG 2 tablets three times per day.
-Mirtazapine 15 MG one tablet by mouth in the morning.
-Omeprazole 40 MG one capsule in the morning.
-Oxycodone HCL 10 MG one tablet by mouth three times a day.
-Paroxetine HCL 20 MG one tablet by mouth at bedtime with 40 MG to equal 60 MG.
-Quetiapine Fumarate 200 MG one tablet at bed time.
-Rozerem 8 MG one tablet at bedtime.
-Methadone HCL 10 MG take two tablets four times per day.
-Movantik 25 MG one tablet in morning every 72 hours.

Surveyor interviewed Manager A on 10/04/2023 at 9:56 AM. Manager A stated Resident 1 left the facility on 09/02/2023 for an overnight visit with family. The facility did send Resident 1's medication for 09/02/2023 with the exception of the Methadone and Oxycodone. They were not aware that Resident 1 was going to be gone longer than the night. Manager A stated they tried calling Resident 1 a few times however, s/he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018097	A. BUILDING: _____ B. WING _____	R-C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY LIVING OF BROOKFIELD LLC	460 LEANORE LANE 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
M 582	Continued From page 27 would state s/he is coming home soon and then did not so they were not able to provide medication to Resident 1 from 09/03/2023 to 09/09/2023 return date. Surveyor asked if they documented sending the 09/02/2023 medications with Resident 1, Manager A stated they did not. Surveyor asked if they documented why Resident 1 did not get the medications on 09/03/2023 to 09/08/2023; Manager A stated they did not but saw there were initials in the record stating "WF". Surveyor asked what the meaning of "WT" was. Manager A stated s/he did not know. Cross Reference: N0216 DHS 88.04(2)(a) Responsibilities N0230 DHS 88.04(2)(f) Condition which represents risk of harm	M 582		