

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 08/19/2024, Surveyor conducted a standard licensure survey and a verification visit at Community Living of Brookfield LLC. Three deficiencies were identified. Two of 3 deficiencies were repeat deficiencies (see Statement of Deficiency (SOD) Q1E311 and SOD Q1E312. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}		
{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 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 observation, record review, and interview, the provider did not ensure accurate records were kept of all prescription medications administered for 2 of 4 records reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) Q1E311, dated 11/08/2022, and SOD Q1E312, dated 10/04/2023.	{M 466}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 466}	Continued From page 1 Resident 1's and 3's Medication Administration Records (MAR) were not correctly documented during medication administration. The MARs were documented with the code "Refused by Resident" when the medication was not available. Medications were documented as administered when the medication was not available. Findings include: On 08/19/2024, Surveyor reviewed Resident 1's and Resident 3's record. Example 1: Resident 1 On 08/19/2024, at approximately 11:45 AM, Surveyor observed Resident 1's blister cards of Methadone. The cards had been dispensed on 08/09/2024. Surveyor noted the AM blister card had 1 remaining tablet; the Noon blister card was empty; the HS (evening) blister card had 2 remaining tablets; and the Overnight blister card was empty. Resident 1's August 2024 MAR, dated 08/01/2024 to 08/19/2024, documented: "Methadone HCL 10 MG (milligram) - Take 3 Tablets (30 MG) by Mouth at 6AM and Take 2 Tablets (20 MG) by Mouth at 10 AM, at Noon and at 10 PM." Start Date: 08/01/2024. 08/01 6:18 AM - Refused by Resident 08/01 9:27 AM- Other 08/02 12:37 PM- Refused by Resident 08/06 6:17 AM- Refused by Resident 08/07 12:59 PM- Refused by Resident 08/07 12:59 PM- Refused by Resident 08/08 11:58 AM- Other - Not available 08/08 11:58 AM- Other - Not available 08/08 9:57 PM- Refused by Resident 08/08 9:57 PM- Refused by Resident	{M 466}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 466}	Continued From page 2 08/09 6:04 AM- Refused by Resident 08/09 6:05 AM- Refused by Resident 08/09 12:51 PM 08/09 12:51 PM- Other - Not available 08/09 12:51 PM- Other - Not available 08/09 3:22 PM- Refused by Resident 08/09 3:23 PM- Refused by Resident 08/10 1:19 PM- Other 08/10 1:19 PM- Other 08/13 10:29 PM- Refused by Resident 08/14 5:57 AM- Refused by Resident 08/14 10:13 PM- Refused by Resident 08/15 5:55 AM- Refused by Resident 08/15 12:11 PM- Other - Not available 08/15 12:12 PM- Other - Not available 08/15 12:13 PM- Other 08/15 12:29 PM- Other 08/15 12:30 PM- Other 08/15 12:51 PM- Other - Not a valid order Surveyor noted the MAR documented the 6:00 AM dose as a duplicate from 08/10 to 08/15/2024 and staff documented the medication was given twice at 6:00 AM from 08/10 to 08/12/2024 and 08/15/2024. Surveyor noted the MAR documented a 2:00 PM dose from 08/08 to 08/15/2024 when there was not a written order for that time. Staff documented the medication was given 08/10 to 08/12/2024. Surveyor noted the MAR documented the 10:00 PM dose as a duplicate from 08/08 to 08/15/2024 and staff documented the medication was given twice at 10:00 PM from 08/10 to 08/12/2024. On 08/19/2024, at approximately 1:00 PM, Surveyor interviewed Administrator O. Administrator O stated there were concerns with how the medication was listed on the MAR and s/he would be reviewing that immediately.	{M 466}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 466}	Continued From page 3 Administrator O stated staff should not be documenting that a resident refused a medication when the medication is not available. Example 2: Resident 3 Resident 3's August 2024 MAR, dated 08/01/2024 to 08/19/2024, documented: "Rybelsus *BULK* 14 MG - Take 1 Tablet by Mouth in the Morning." 08/02 - Other 08/06 - Other - Not Available 08/07- Other - Not Available 08/08- Other - Not Available 08/09- Other - Not Available 08/10- Other - Not Available 08/13- Other - Not Available 08/15- Other 08/16- Other 08/17- Other - Not Available 08/18- Other - Not Available On 08/19/2024, at approximately 1:00 PM, Surveyor interviewed Administrator O. Administrator O stated the medication was unavailable and staff should not have documented that it had been administered. Cross Reference: M0582 DHS 88.10(3)(q) Medications	{M 466}			
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner.	M 474			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 474	Continued From page 4 This Rule is not met as evidenced by: Based on observation and interview, the provider did not store food under sanitary conditions. Surveyor found food items in the refrigerator that were not properly sealed to avoid contamination and food items in the freezer that were not properly sealed to avoid freezer burn. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses. Findings include: The licensee can serve up to 4 residents within the client groups of Physically Disabled, Irreversible Dementia/Alzheimer's, Alcohol/Drug Dependent, Developmentally Disabled, Terminally Ill, and Traumatic Brain Injury. On 08/19/2024, at approximately 11:25 AM, Surveyor toured the kitchen and observed the following: Refrigerator: -An opened 16 ounce jar of alfredo pasta sauce that was not dated. -(2) opened packages of bacon strips that was not sealed or dated. -A plastic grocery bag of a soft food item that was not labeled and dated. -A plastic container with a red lid with what appeared to be left over macaroni and cheese that was not dated. -(2) opened jars of marinara pasta sauce. -An opened package of a polish sausage ring that was not sealed or dated. -A cooking pan of what appeared to be leftover spaghetti with a meat sauce that was not sealed or dated.	M 474		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 474	Continued From page 5 Freezer: -An opened package of beef steak that was not sealed. -A box of hamburger patties that was not sealed. Hamburger patties were falling out of the box. "Time/temperature control for safety (TCS) guidelines indicate food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated, RTE (ready-to-eat)/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded." (US Food and Drug Administration (FDA) Food Code, 2022, Section 3-501.17) "Ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored for only seven days if it is held at 41 degrees Fahrenheit or lower. The count begins on the day the food was prepared or a commercial container was open. TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables." (ServSafe Coursebook, 7th edition, 2017, p. 1-7, p. 1-8, and p. 7-3)	M 474		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 474	Continued From page 6 "If you do not seal your food it can get "freezer-burn". This means that water escapes from the food and moves to the coldest part of the freezer - leaving your food dehydrated." (Source: Safefood website, Storing food in the freezer, 2024, https://www.safefood.net/food-storage/freezing (retrieval date - August 19, 2024).) On 08/19/2024, at approximately 1:15 PM, Surveyor interviewed Licensee D and Administrator O. Surveyor did not receive a response.	M 474		
{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 observation, record review, and interview, the provider did not ensure 4 of 4 residents (Resident 1) received all prescribed medications. This is a repeat deficiency see Statement of Deficiency (SOD) Q1E312 dated 10/04/2023. Resident 4's Lactulose was not available for med administration 06/01/2024 to 08/18/2024.	{M 582}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 7 Findings include: On 07/30/2024, Surveyor reviewed Resident 1's, Resident 2's, Resident 3's, and Resident 4's record. Example 1: Resident 1 Resident 1's June and July2024 MARs documented: "Spiriva Handihaler - inhale contents of 1 capsule via handihaler in the morning. Scheduled at 8:00 AM. Start Date: 07/24/2023." The June MAR documented 2 out of 30 opportunities as "Refused by Resident;" 6 out of 30 opportunities as "Other - Not Available." Resident 1 was documented as receiving the prescribed medication 22 out of 30 opportunities. The July MAR documented 1 out of 31 opportunities as "Refused by Resident;" 8 out of 31 opportunities as "Other - Not Available." Resident 1 was documented as receiving the prescribed medication 22 out of 31 opportunities. On 08/19/2024, at approximately 1:00 PM, Surveyor interviewed Licensee D and Administrator O. Surveyor did not receive a response regarding the concerns. Example 2: Resident 2 On 08/19/2024, at approximately 11:45 AM, Surveyor reviewed Resident 2's medications. Surveyor observed an opened inhaler (albuterol) that was not in its original container and did not contain a label that identified the resident's name or the prescription. The inhaler had a date of May 2022 stamped on it.	{M 582}			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 8 Resident 2's June, July, and August 2024 MARs documented: "Albuterol Sulfate - Inhale 2 puffs into the lungs daily as needed. Max of 12 puffs per 24 hours." "Expiration dates for inhalers are often printed on the box or foil packaging. A secondary expiration date is frequently imprinted on the inhaler canister. If you can't find the expiration date, call your pharmacist, and ask when your last prescription was filled. If it has been more than a year, this inhaler is expired." (Source: Healthline website, Is It Safe to Use an Expired Inhaler?, May 19, 2023, https://www.healthline.com/health/asthma/can-you-use-an-expired-inhaler (retrieval date - August 19, 2024).) Resident 2's June, July, and August 2024 MARs documented: "Valproic Acid - Take 3 teaspoonfuls (15 MLS) (750 MG) per G-Tube 3 times a day. Scheduled at 8:00 AM, 4:00 PM, 8:00 PM. Start Date: 01/23/2024." The June MAR documented 1 out of 90 opportunities as "Refused by Resident;" 26 out of 90 opportunities as "Other - Not Available." Resident 2 was documented as receiving the prescribed medication 63 out of 90 opportunities. The July MAR documented 18 out of 93 opportunities as "Refused by Resident;" 39 out of 93 opportunities as "Other - Not Available;" 1 medication administration was left blank." Resident 2 was documented as receiving the prescribed medication 35 out of 93 opportunities. The August MAR documented 10 out of 54 opportunities as "Refused by Resident;" 8 out of 54 opportunities as "Other - Not Available." Resident 2 was documented as receiving the	{M 582}			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 9 prescribed medication 36 out of 54 opportunities. On 08/19/2024, at approximately 1:00 PM, Surveyor interviewed Licensee D and Administrator O. Surveyor did not receive a response regarding the concerns. Example 3: Resident 3 Resident 3 was admitted to the facility 08/27/2021. On 08/19/2024, at approximately 11:45 AM, Surveyor reviewed Resident 3's medications. Surveyor observed an opened bottle of Systane (eye drops) with a dispensed date of 10/24/2023. The bottle was not labeled as to when it had been opened. Resident 3's June, July, and August 2024 MAR documented: "Systane - Instill 1 drop in both eyes 4 times a day as needed (dry eyes)." The MARs did not document that the Systane had been administered. "As with most medications, this product should be stored at room temperature. Store it in a secure location where it will not be exposed to excessive heat, moisture, or direct sunlight. Once opened, the product must be used within 30 days. Any unused portion should be discarded." (Source: Familiprix website, Systane Original eye drops, 2024, https://www.familiprix.com/en/medications/systane-original-eye-drops-02248967 (retrieval date - August 19, 2024).) On 08/19/2024, at approximately 1:00 PM, Surveyor interviewed Licensee D and	{M 582}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 10 Administrator O. Surveyor did not receive a response regarding the concerns. Example 4: Resident 4 Resident 4 was admitted to the facility 07/02/2021. On 08/19/2024, at approximately 11:45 AM, Surveyor reviewed Resident 4's medications. Surveyor observed the following medication packets: 08/12 8:00 AM - Metoprolol ER Succinate, Loratadine, Quetiapine, Sertraline, Aspirin, Senna-Docusate 08/15 8:00 AM - Acetaminophen, Calcium with Vitamin D, Lactase Resident 4's August 2024 MAR documented that Resident 4 had received all his/her medications on 08/12/2024 and 08/15/2024. Resident 4's June, July, and August 2024 MAR, dated 06/01/2024 to 08/18/2024, documented: "Lactulose 10 gram / 15 ML (milliliter) - Take 45 MLs (30 MG) by mouth 2 times a day. Scheduled at 8:00 AM and 8:00 PM. Start Date: 05/01/2024." The June MAR documented 18 out of 60 opportunities as "Refused by Resident;" 19 out of 60 opportunities as "Other - Not Available." Resident 4 was documented as receiving the prescribed medication 23 out of 60 opportunities. The July MAR documented 20 out of 62 opportunities as "Refused by Resident;" 28 out of 62 opportunities as "Other - Not Available." Resident 4 was documented as receiving the prescribed medication 14 out of 62 opportunities. The August MAR documented 11 out of 36 opportunities as "Refused by Resident;" 5 out of	{M 582}			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/19/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY LIVING OF BROOKFIELD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 11 36 opportunities as "Other - Not Available." Resident 4 was documented as receiving the prescribed medication 20 out of 36 opportunities. On 08/19/2024, at approximately 1:00 PM, Surveyor interviewed Licensee D and Administrator O. Surveyor did not receive a response regarding the concerns. Cross Reference: M0466 DHS 88.07(3)(e)1. Medication - Record Keeping	{M 582}			