

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 510386	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/25/2026
NAME OF PROVIDER OR SUPPLIER BROOKDALE LACROSSE MC		STREET ADDRESS, CITY, STATE, ZIP CODE 3161 E AVENUE SOUTH LA CROSSE, WI 54601		
(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 08/25/2026, Surveyor conducted a verification visit and 2 complaint investigations at Brookdale Lacrosse MC. Both complaints were substantiated. Three deficiencies were identified. Two of the 3 deficiencies were repeat violations. See Statement of Deficiency (SOD) QBW11, dated 01/08/2025, SOD QBW12, dated 08/26/2025 and SOD QBW113, dated 03/10/2026. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 19	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2's legal representative was immediately notified when there was an incident affecting the resident.	N 169		

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

TITLE

(X6) DATE

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N 169	Continued From page 1 Findings include: On 05/21/2026, the department received a self-report detailing Resident 2's fall that took place at approximately 7:00 PM on 05/14/2026. On 05/26/2026 and 05/27/2026, the department received complaints alleging the provider did not notify legal representatives of incidents/injuries. On 08/25/2026, Surveyor reviewed Resident 2's closed record and identified the following: Resident 2 was admitted on 04/15/2026 and had multiple diagnoses including dementia. Resident 2 had a legal decision maker. Resident 2 was discharged on 06/09/2026. At approximately 12:30 PM, Surveyor interviewed Executive Director (ED) A. When asked about the provider's fall policies, ED A stated they always notified the residents' legal decision makers. When asked about Resident 2's fall on 05/14/2026, ED A stated the fall took place under a different nurses' time of employment. ED A stated the nurse was terminated after the fall and it was possible someone was not notified. ED A stated the provider offered to send Resident 2 to the emergency room (ER) the morning after the fall, but the family declined. ED A stated the family later took Resident 2 in on their own. Surveyor requested any investigations completed related to the fall. At approximately 1:20 PM, ED A brought a document to Surveyor which s/he described as an internal document. ED A read from the document and stated during the investigation, the previous nurse acknowledged s/he did not assess	N 169		

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N 169	Continued From page 2 the resident or call family because it was very late. Staff had assured the nurse Resident 2 was stable. The nurse admitted it was a mistake and stated s/he felt there was too much going on and pulled his/her attention to other matters. The provider did not ensure the legal representative of Resident 2 was immediately notified when Resident 2 experienced a fall and was later seen in the ER.	N 169			
{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 observation, record review, and interview, the provider did not ensure residents received all medications in the dosages and at intervals prescribed by a practitioner. Resident 1 did not receive his/her scheduled multivitamin on 08/25/2026. Resident 1 did not receive his/her scheduled metoprolol medication for at least 9 days in June 2026. This is a repeat deficiency. See Statement of Deficiency (SOD) QBW11, dated 01/08/2025, SOD QBW12, dated 08/26/2025 and SOD QBW113, dated 03/10/2026.	{N 352}			

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{N 352}	Continued From page 3 Findings include: The provider is licensed to care for 33 residents in the client groups of irreversible dementia/Alzheimer's disease and advanced aged. On 08/25/2026, at approximately 12:55 PM, Surveyor requested Resident 1's June through August 2026 Medication Administration Record (MAR) from Executive Director (ED) A. Resident 1 was admitted on 05/23/2026 and had multiple diagnoses including essential primary hypertension. Resident 1's June 2026 MAR included the following: Metoprolol Tartrate Oral Tablet 50 MG. Give 1 tablet by mouth at bedtime related to essential primary hypertension. The medication was scheduled at 8:00 PM. On 06/14/2026, 06/15/2026, 06/18/2026, 06/19/2026, 06/20/2026, 06/22/2026, 06/24/2026, 06/25/2026, and 06/26/2026, there was a "20" code entered in the designated space. The key code on the MAR identified 20 as meaning, "Medication/Treatment Not Available/Pharmacy Action." On 06/16/2026, 06/17/2026, 06/21/2026, 06/23/2026, 06/28/2026, 06/29/2026, and 06/30/2026, there was an "18" entered. The key code on the MAR identified 18 as meaning, "Other/See Med (Medication) Note." Resident 1's August 2026 MAR included the following: Multivitamin Oral Tablet. Give 1 tablet by mouth 1 time a day for supplement. The medication was	{N 352}		

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{N 352}	Continued From page 4 scheduled at 8:00 AM. On 08/16/2026 and 08/20/2026, there was a "20" code entered in the designated space. On the day of survey, there was an "18" entered. At approximately 2:20 PM, Surveyor observed the medication cart with ED A. Surveyor requested to review Resident 1's multivitamin medication packaging. The multivitamin package was full, containing medication in all available slots, including that morning's scheduled dose. Director of Finance (DOF) B approached Surveyor and ED A at the medication cart. When asked about the full medication pack, DOF B stated Veterans Affairs (VA) did not get the medication shipped in until that day. ED A stated they have had issues with getting medications from the VA timely. When asked about Resident 1's metoprolol that had been marked with 18's and 20's in June 2026, ED A stated the medication was probably out at that time. The provider did not ensure residents received all medications in the dosages and at intervals prescribed by a practitioner. Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration.	{N 352}			
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication	{N 415}			

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{N 415}	Continued From page 5 administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review, and interview, the provider did not ensure Resident 1 had his/her medication administration accurately documented. This is a repeat deficiency. See Statement of Deficiency (SOD) QBW112, 08/26/2025 Findings include: On 08/25/2026, at approximately 12:55 PM, Surveyor requested Resident 1's June through August 2026 Medication Administration Record (MAR) from Executive Director (ED) A. Resident 1's August 2026 MAR included the following: Multivitamin Oral Tablet. Give 1 tablet by mouth 1 time a day for supplement. The medication was scheduled at 8:00 AM. On 08/16/2026 and 08/20/2026, there was a "20" code entered in the designated space. On the day of survey, there was an "18" entered. The key code on the MAR identified 20 as meaning, "Medication/Treatment Not Available/Pharmacy Action." The key code on the MAR identified 18 as meaning, "Other/See Med (Medication) Note." The medication was signed as administered on 08/18/2026, 08/21/2026, and 08/23/2026.	{N 415}		

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{N 415}	Continued From page 6 At approximately 2:20 PM, Surveyor interviewed Executive Director (ED) A and Director of Finance (DOF) B near the medication cart. Surveyor observed the packaging with medication filled in all available slots. DOF B stated the provider received Resident 1's multivitamin shipment that day. At approximately 3:00 PM, Surveyor interviewed ED A. Surveyor shared concerns with the multivitamin medication being signed as administered on 08/18/2026, 08/21/2026, and 08/23/2026 when it was confirmed to be out and received by the provider on 08/25/2026. ED A stated it was probably a medication error. The provider did not ensure Resident 1 had his/her medication administration accurately documented when his/her multivitamin was signed as administered when it was not available. Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	{N 415}		