STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020926	A. BUILDING: _____ B. WING _____	C 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY COMMONS BROOKFIELD	16040 W GREENFIELD AVE BROOKFIELD, WI 53005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/06/2026, Surveyors conducted a standard survey and 2 complaint investigations at Discovery Commons Brookfield. Three deficiencies were identified. Both complaints were unsubstantiated. Census: 100	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the resident right to receive all prescribed medications in the dosage and at intervals prescribed by a practitioner for 4 of 4 residents reviewed. Resident 1, Resident 3, Resident 4, and Resident 14 did not receive all scheduled medications as ordered by the physician.. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve residents within the client groups of irreversible dementia/Alzheimer's, physically disabled and advanced age.	N 352		

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

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N 352	Continued From page 1 Example 1- Resident 1 On 05/06/2026, Surveyor reviewed Resident 1's record. S/he was admitted 11/09/2022. Schedule physician orders included: rosuvastatin calcium 5 MG 1 tablet at bedtime (start date 03/27/2026); Eliquis 2.5 MG 1 tablet every 12 hours (start date 12/19/2025); levothyroxine sodium 50 MCG 1 tablet at 7 AM (start date 01/28/2026); aspirin EC 81 MG 1 tablet in AM (start date 12/19/2025); Jardiance 10 MG 1 tablet in AM (start date 12/19/2025); metoprolol succinate 50 MG 1 tablet in AM (start date 12/19/2025); spironolactone 25 MG ½ tablet (12.5 MG) in AM (start date 12/19/2025); vitamin D3 2,000 Units 1 capsule in AM (start date 12/19/2025); and furosemide 20 MG 1 tablet in morning (start date 04/11/2026). April 2026 Medication Administration Record (MAR) : On 04/21/2026 during the 8:00 PM medication pass and 04/22/2026 during the 8:00 AM medication pass staff documented the medications (including rosuvastatin calcium, Eliquis, levothyroxine, aspirin, Jardiance, spironolactone, vitamin D3, and furosemide) were not administered due to not being on the (medication) cart . Individual Service Plan (ISP) (not signed or dated): In the area of Medications- " ...Resident will have all physician prescribed medications, reordered in a timely manner to be administered daily as needed ..." On 05/06/2026 at 2:02 PM, Surveyor interviewed Executive Director A who stated medications were packaged in strips comprised of individual	N 352		

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N 352	Continued From page 2 pouches, and each pouch contained all tablets/capsules for each med pass. Executive Director A stated when Resident 2 had a medication change on 04/21/2026, the pharmacy driver arrived to pick up his/her strip but staff inadvertently gave the driver Resident 1's medication strip. On 05/06/2026 at 2:09 PM, Executive Director A and Surveyor called Pharmacy Client Service C who stated pharmacy issued a pick up for Resident 2's 04/21/2026-04/23/2026 medications due to an order change and explained pharmacy drivers brought empty medication bag(s), form(s) with the resident's name, name of medication to pick up and reason for pick up to facility when medications were picked up, and 24 hours worth of medication including the newly ordered medication for staff to administer until pharmacy delivered a new strip. Pharmacy Client Services C stated during pick-ups, facility staff removed the medications from the medication cart and either facility staff or pharmacy driver put the medication in the bag. Pharmacy Client Services C stated on 04/21/2026 the driver picked up the medication between 7:30 PM and 8:00 PM, and at approximately 8:30 AM on 04/22/2026 Resident 1's medications were reassigned for delivery and delivered by 9:00 AM on 04/22/2026. On 05/06/2026 at approximately 2:14 PM immediately following phone call with Pharmacy Client Services C, Executive Director A stated to Surveyor the med techs needed to know, when calling pharmacy, how to press phone line # to reach after hours on call pharmacy staff. Executive Director A stated s/he had reiterated to staff to double check and sign for every medication put in the pharmacy medication bag and to not sign for medications unless they were	N 352		

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N 352	Continued From page 3 positive the correct medications were in the bag. Example 2- Resident 3 On 05/06/2026, Surveyor reviewed Resident 3's record. S/he was admitted 10/14/2024. Scheduled physician orders included: Myrbetriq 25 mg 1 tablet in the morning; Divalproex 125 mg 1 capsule 2 times a day; Loperamide 2 mg 1 tablet by mouth 2 times a day; and Rivastigmine 9.5 mg/ 24 hr 1 patch daily. February 1st - May 5th, 2026, MAR: The following medications were not administered on many occurrences for reasons documented as "other, unavailable, or med not available" from February 1st to April 30th: Myrbetriq- 29 occurrences Divalproex- 21 occurrences Loperamide- 30 occurrences Rivastigmine- 6 occurrences ISP dated 08/06/2025: "Meds 3-4 x daily: [Resident 3] will receive medications via med tech as ordered by MD ..." Progress notes dated 02/01/2026 - 05/06/2026 included the following: "05/05/2026 12:00 PM- Writer contacted ALPS and spoke with pharmacy staff in regard to [Resident 3's] Myrbetriq, ALPS is requiring a prior auth. Calls made to medical provider." On 05/06/2026 at approximately 4:00 PM, Surveyor interviewed Executive Director A. Executive Director A stated s/he was not sure why there were issues regarding medications not being available, and that they would have to investigate further. Surveyor also interviewed	N 352		

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N 352	Continued From page 4 Memory Care (MC) Director E. MC Director E stated Resident 3 had frequent medication changes and explained some of Resident 3's medications required prior authorizations, so it was sometimes challenging to get refills. Example 3- Resident 4 On 05/06/2026 at approximately 10:25 AM, Surveyor toured the medication cart for the provider's memory care unit. Surveyor observed a bag containing individual packs of cholestyramine. The pharmacy tag included the following information: [Resident 4] Date: 12/05/2025 Cholestyramine 4 Gram Powder Pack- Dissolve contents of 1 packet in liquid as directed in the morning with breakfast. Qty (quantity): 28 On 05/06/2026 at approximately 10:45 AM, Surveyor interviewed MC Director E. MC Director E reviewed the MAR and verified the cholestyramine is still a scheduled medication for Resident 4. S/he stated Resident 4 is not a resident who usually refuses medication. MC Director E stated they sometimes get an overstock of supplies because some things are sent automatically by pharmacy, so there could have been other bags dated more recently that were used out of order. Surveyor requested pharmacy delivery records from MC Director E, who stated s/he would get them from the pharmacy. On 05/06/2026 Surveyor reviewed pharmacy delivery records provided by MC Director E. The	N 352		

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delivery records included deliveries on 11/07/2025, with 28 packets delivered, and another on 12/05/2025, with 28 packets delivered.

On 05/06/2026, Surveyor reviewed Resident 4's record. S/he was admitted 03/28/2024. Scheduled physician orders included: Cholestyramine 4 grams dissolve 1 packet in liquid in the morning with breakfast.

The MAR was reviewed from February 1st - May 5th, 2026, and did not include any documented refusals of cholestyramine.

Based on the information above and the delivery records, Resident 4 only received 52 of 186 doses from 11/07/2025 to 05/06/2026.

Example 4 - Resident 14

On 05/06/2026 at approximately 11:30 AM, Surveyors completed a medication cart audit with Res Care Coord D. Surveyors observed that Resident 14 had an inhaler of fluticasone-salmeterol that had an open date of 09/15/2025 that still had 50 puffs in the inhaler.

On 05/06/2026 at 11:35 AM, Surveyors interviewed Res Care Coord D. Res Care Coord D stated that all the extra medications should be stored in the medication room and not on the cart. Res Care Coord D stated that there was no one on this side of the facility that had a lot of refusals. Res Care Coord D stated that if a resident did refuse the medication, it would be documented on the MAR. Res Care Coord D acknowledged that the fluticasone-salmeterol inhaler was dated 09/15/2025. Res Care Coord D did not know why the inhaler was in the

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medication cart for that long. Surveyor noted that the packaging for the Fluticasone-salmeterol indicated the inhaler contained 60 puffs and would last 30 days if given 2 times a day as prescribed.

Surveyor reviewed Resident 14's record. Resident 14 was admitted to the provider's facility on 09/26/2022 with a diagnosis of asthma. Resident 14's physician order included the following:

-Fluticasone-salmeterol 250-50 mcg at 8 AM and 8 PM(start date 01/06/2026) ;Furosemide 20mg 8 AM (start date 11/23/2025);Gabapentin 100 mg 8 PM (start date 09/16/2025); Glucosamine-chondroitin 500-400 mg 8 PM (start date 09/16/2025); Losartan potassium 100 mg 8 AM (start date 09/16/2026); Betoptic .25% 8 Am and 5 PM (start date 09/16/2026); Calcium 600 vit D3 600 mg 8 AM (start date 09/16/2025); Potassium chloride 20 meq 8 AM and 8PM (start date 09/16/2025); Pyridostigmine bromide 60 mg 8 AM and 8 PM (start date 09/16/2025); Refresh optive sensitive .5-.9% 8 AM and 8 PM (start date 09/16/2025);

Surveyor reviewed the Medication Administration Record (MAR), dated 02/01/2026 through 05/05/2026. The MAR indicated that fluticasone-salmeterol 250-50 was passed every day from 02/01/2026 through 05/05/2026. The MAR did indicate 11 refusals from 02/01/2026 through 05/05/2026.

On 05/06/2026 at approximately 5:00 PM, Surveyors shared the concern of the inhaler with an open date of 09/15/2025 with 50 puffs remaining, with Executive Director A and Health and Wellness Director B. Executive Director A

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N 352	Continued From page 7 stated that s/he did not understand how a medication could be on the medication cart that long as the cart was supposed to be checked weekly. Executive Director A stated that the facility would be auditing the medication carts as soon as possible with the new Health and Wellness Coordinator.	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure individual service plan (ISP) was revised annually or when there was a change in resident's needs, abilities or mental or physical condition, and the ISPs were signed by the resident or resident's legal representative acknowledging their involvement in, understanding of and agreement with the ISP for 2 of 5 residents reviewed. Resident 1's ISP did not identify	N 389		

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self-administration of injectable medication. Resident 13's ISP was no updated annually and signed.

Findings include:
The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve residents within the client groups of irreversible dementia/Alzheimer's, physically disabled and advanced age.

Example 1- Resident 1
On 05/06/2026 at 9:22 AM, Surveyor interviewed Resident 1 who stated s/he administered his/her own insulin and staff administered his/her topical ointments/creams and oral medications.

On 05/06/2026 at 1:03 PM, Surveyor interviewed Resident Care Coordinator D who stated s/he was hired October 2025 and Resident 1 administered his/her own insulin since s/he was hired.

On 05/06/2026, Surveyor reviewed Resident 1's record. S/he was admitted 11/09/2022.

Physician orders included Lanatus Solostar 100 UNIT/ML (3 ML) inject 12 units subcutaneously in morning and 7 UNITS at bedtime.

Medication administration record (MAR)- From 04/01/2026-04/30/2026, staff documented Resident 1 self-administered Lantos Solostar insulin 10 times.

ISP- The ISP was not signed or dated.
In the area of Non-Oral Medications " ...Resident requires assistance to administer medication other than oral ...Who is Responsible: med tech...Resident will have all prescribed, non-oral

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N 389	Continued From page 9 medications administered ..." Example 2- Resident 13 On 05/06/2026 at approximately 11:00 AM, Surveyor reviewed Resident 13's record. S/he was admitted to facility on 05/30/2024. Surveyor noted that the date on the ISP was 03/20/2025 and was signed by Resident 13 but the signature page was not dated. Surveyor observed that the ISP, dated 03/20/2025, was in a different format than other ISP records that the facility had provided. On 05/06/2026 at approximately 1:55 PM, Surveyor interviewed Executive Director A. Executive Director A stated that there had been a lot of turnover in the Wellness Director position. Executive Director A stated that the facility had just hired a new Wellness Director, and s/he started on 05/04/2026. Executive Director A said that the facility did not have an updated annual ISP for Resident 13. On 05/06/2026 at 5:00 PM, Surveyors shared concern with Executive Director A and Health & Wellness Director B regarding the ISP that had not been updated annually. The ISP, dated 03/20/2025 contained a signature page that was signed but not dated in the record. Executive Director A acknowledged that the facility was behind with the annual ISP's. Executive Director A stated that the facility would be getting the ISP's updated as soon as possible.	N 389		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be	N 406		

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sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure medications that had expired were removed from the medication cart and disposed of within 30 days.

Findings include:

On 05/06/2026 at approximately 10:20 AM, Surveyor toured the provider's memory care unit. Surveyor reviewed the medications within the medication cart for memory care and observed the following:

- Resident 5 had 1 bubble pack of as needed (PRN) Acetaminophen, with 5 doses remaining,

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which was dated to discard after 02/2026.
- Resident 5 had 1 bubble pack of PRN Hydroxyzine, with 11 doses remaining, dated to discard after 02/2026.
- Resident 5 had 1 bubble pack of PRN Hyoscyamine, with 11 doses remaining, dated to be discarded after 03/2026.
- Resident 6 had 1 bubble pack of PRN Olanzapine, with 8 doses remaining, dated to be discarded after 01/2026.
- Resident 7 had 2 bubble packs of PRN Acetaminophen, with 32 doses remaining, dated to be discarded after 02/2026.
- Resident 8 had 1 bubble pack of PRN Cyclobenzaprine, with 15 doses remaining, dated to discard after 02/2026.
- Resident 9 had 1 bubble pack of PRN Cyclobenzaprine, with 17 doses remaining, dated to discard after 03/2026.

On 05/06/2026 at approximately 10:45 AM, Surveyor interviewed Memory Care (MC) Director E. MC Director E stated the medication cart should be checked frequently by a nurse and/or the med techs. S/he stated they should check for several things including expired medications or missed medications. MC Director E said the provider used to utilize a checklist for completing medication audits but utilizing that had fallen through the cracks.

On 05/06/2026 at approximately 11:40 AM, Surveyor toured the assisted living halls on the first floor. Surveyor reviewed the medications within the medication cart for 1st floor, called "Cart 1", and observed the following:

- Resident 10 had 1 bubble pack of PRN Ibuprofen, with 20 doses remaining, dated to discard after 03/2026.

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N 406	Continued From page 12 - Resident 11 had 1 bubble pack of PRN Acetaminophen, with 4 doses remaining, dated to discard after 12/2025. - Resident 2 had 2 bubble packs of PRN Ondansetron, with 10 doses remaining in 1 pack, dated to discard after 02/2026, and 16 doses remaining in the other pack, dated to discard after 01/2026. - Resident 2 had 2 bubble packs of PRN Acetaminophen, with 46 total doses remaining, both dated to discard after 01/2026. - Resident 12 had 4 bubble packs of PRN Ibuprofen, with 91 total doses remaining, all dated to be discarded after 12/2025. - Resident 12 had 1 bubble pack of PRN Ibuprofen, with 27 doses remaining, dated to be discarded after 01/2026. - Resident 12 had 1 bubble pack of PRN Acetaminophen, with 2 remaining doses, dated to be discarded after 01/2026. On 05/06/2026 at approximately 4:00 PM, Surveyor interviewed Executive Director A regarding the expired medication. Executive Director A took note of the concerns. Executive Director A was not aware of the expired medications and stated that the pharmacy had even been there to complete audits since the time some of the medications had expired. Executive Director A stated there are many plans being reimplemented as s/he has 2 new nurses hired for the facility.	N 406		