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{N 000}	Initial Comments On 07/15/2026, with information gathered through 07/23/2026, the Bureau of Assisted Living, Southern Regional Office conducted 4 complaint investigations, 2 self-report investigations, and a verification visit of statement of deficiency (SOD) RRPX13 at Auberge At Brookfield Memory Care Community, located at 1105 Davidson Rd in Brookfield, WI. Six citations of noncompliance were issued, 2 of which are repeat violations of compliance. Two of 4 complaints were substantiated. Census: 57 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injuries of an unknown source were investigated. Resident 12 experienced bruising on his/her inner thighs with unknown source, that was not investigated. This requirement is being cited for a third time. See Statement of Deficiency (SOD) Y77R14,	N 161		

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

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issued on 11/28/2023, and SOD Y77R12, issued 02/08/2023.

The findings include:

On 07/15/2026 at 9:10 A.M., Surveyor conducted an interview with Facility Nurse L. Facility Nurse L identified Resident 12 as someone who recently had an injury of an unknown origin. S/he stated there was bruising to the inside of both Resident 12's thighs. Facility Nurse L told Surveyor Resident 12's Legal Representative Q sent photos to Interim Administrator K. Facility Nurse L said Legal Representative Q communicated s/he thought the bruising to Resident 12's thighs were caused by caregivers prying Resident 12's legs open to provide cares. Facility Nurse L said s/he and Resident 12's hospice agency nurse assessed the bruises. Facility Nurse L said s/he did not document the assessment nor did s/he conduct and document an investigation regarding the bruising of unknown source and stated, "No reason" when asked why s/he had not done so.

On 07/15/2026 Surveyor reviewed Resident 12's record and identified the following:
Resident 12 admitted to the facility on 07/16/2025 with diagnoses of dementia, repeated falls, and urinary incontinence.

Surveyor reviewed Resident 12's progress notes from 03/09/2026 - 07/15/2026. There was no documentation within the progress notes of the bruising, or incidents that appeared to correlate with such an injury.

Surveyor reviewed Resident 12's medical appointment records which included a visit with his/her PCP on 07/08/2026. The note states: "Chief Complaints: Acute visit for bruising to

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N 161	Continued From page 2 BLE's, hospice care ... History of Present Illness: ... Per staff, no recent falls, hospitalizations or infections since last visit; bruises on BLEs "from roughness" during cares reported by nurse and hospice RNCM. These concerns are being addressed by facility ... Treatments: ... ASHD (atherosclerotic heart disease)/ History TIA (labile) - On ASA (aspirin), Plavix - Hospice RNCM to educate POA these meds may increase fragile skin, easy bruising - may DC meds if POA agreeable ..." Surveyor reviewed Resident 12's hospice nursing visit notes which included a visit with an RN on 07/13/2026. The note states: " ... Plan for next visit: Assess bruising. Additional information/comments: No S/S of pain noted. Bruising around bilateral thighs healing, now turning yellow. [Resident 12] reports no pain in this area. Continued education provided to caregivers regarding transferring and changing Pt. Will continue to monitor." On 07/15/2026 at approximately 12:30 PM, Surveyor interviewed Interim Administrator K regarding the injury Resident 12 experienced. Interim Administrator K stated Legal Representative Q came to him/her with the concerns, and s/he asked Legal Representative Q to take the concerns to Facility Nurse L. Interim Administrator K reported Legal Representative Q stated, "I think it happened when [Resident 12] was being changed [provided incontinence care]." Surveyor asked Interim Administrator K what would be included in an investigation for an injury of unknown source and s/he stated, "Skin checks, assessments of mood/ behavior or other changes, and interviews of people involved in [Resident 12's] cares." Interim Administrator K also stated this information should be	N 161		

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N 161	Continued From page 3 documented. On 07/15/2026 at approximately 5:20 PM, Surveyor interviewed Facility Nurse L. Facility Nurse L stated there was no documentation of an investigation regarding the bruising, because an investigation was not completed. Facility Nurse L stated Legal Representative Q seemed in agreement or content with the "resolution" or assuming the bruising was accidental, during cares.	N 161		
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 observation, interview, and record review, the provider did not ensure Resident 11's legal representative was notified immediately when the facility became aware on or about 04/01/2026 of Resident 11's left eye injury. The findings include: The department received a complaint alleging legal representatives were not notified immediately of resident injuries.	N 169		

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N 169	Continued From page 4 On 07/15/2026 at 8:30 A.M. and 6:38 P.M., Surveyor conducted an interview with Interim Administrator K. Interim Administrator K told Surveyor s/he had been the interim administrator of this facility for approximately 1.5 weeks following Previous Administrator I's termination on 06/26/2026. Interim Administrator K told Surveyor Facility Nurse L's, a registered nurse, hire date was 05/04/2026 and s/he filled the director of wellness position following Previous Agency Nurse J's termination on 05/26/2026. On 07/15/2026 at 10:15 A.M., Surveyor observed Resident 11 ambulating short distances with an unsteady gait in his/her own room. Surveyor observed Resident 11 answered Surveyor's questions with indiscernible speech. On 07/15/2026 at 11:15 A.M., Facility Licensed Practical Nurse (LPN) R told Surveyor Resident 11 came out of his/her room for meals in the main dining room but spent most of his/her time within his/her own room. Facility LPN R said Resident 11 was confused and it was difficult to understand his/her speech. On 07/15/2026, Surveyor reviewed Resident 11's record, as requested and provided by Facility Nurse L. Resident 11's diagnoses included dementia, hypotension (low blood pressure), epilepsy (a seizure disorder), anxiety, and depression. Resident 11's individual service plan (ISP) signed by Resident 11's Legal Representative P included "Communication: Severe Impairment. [Resident 11] is unable to communicate or receive information; has continuous difficulty following instructions with using the telephone, writing letters, and other communication devices."	N 169		

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Resident 11's ISP included, "Long Term Memory: Severe Impairment. [Resident 11] has severe impairment: Unable to remember or use information; may require repeated verbal prompts and/or direction. Orientation: Severe Impairment. [Resident 11] is frequently disoriented and requires frequent supervision and oversight. Short Term Memory: [Resident 11] has severe impairment: Unable to remember or use information; may require repeated verbal prompts and/or direction." Resident 11's ISP included, "Awareness: Occasional Issues. [Resident 11] has current or history of occasional inability to discern and avoid situations that s/he may be abused, neglected, or exploited." Resident 11's ISP included, "Judgement: Occasional poor judgement issues. [Resident 11] may resist care at times. Needs protection and supervision because participant makes unsafe or inappropriate decisions." Resident 11's ISP included, "Mobility/Ambulation: Partial Assist. [Resident 11] may require prompts/cues to use assistive devices, does not require hands on assistance. Wheelchair." Resident 11's ISP included, "Transferring: Partial Assist. [Resident 11] needs reminders or guidance to initiate transfer or the staff is only involved for part of the time." Resident 11's ISP included, "Fall potential." Resident 11's unsigned ISP dated 04/12/2026 included, "Safety and Risk. [Resident 11] will be monitored for safety in their environment. Spot Checks: [Resident 11] will receive regular scheduled spot checks." Neither of Resident 11's ISPs addressed the use of Nobi [an AI (artificial intelligence) fall detection system] within Resident 11's own room.

Resident 11's "progress notes" included a note dated 04/01/2026 at 11:36 A.M. documented by Previous Agency Nurse J. The note included, "Staff reported that [Resident 11] has bruising to

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[his/her] left eye. [Resident 11] stated that [s/he] fell, but cannot confirm with staff, as nobody helped [him/her] get up and no Nobi alert. Denies pain. NP [nurse practitioner] notified." No other documentation associated with a fall and/or injury within Resident 11's progress notes between the previous, unrelated note on 03/11/2023 or the following, unrelated note on 04/08/2026. There was no documentation including Resident 11's Legal Representative P was notified of the injury noted on 04/01/2026.

On 07/15/2026 at approximately 5:00 P.M., Facility Nurse L told Surveyor there was no documented incident report related to Resident 1's eye injury noted on 04/01/2026. Facility Nurse L said there was no documentation this injury was reported to Resident 11's Legal Representative P.

On 07/22/2026 at 3:17 P.M., Surveyor conducted an interview with Resident 11's Funding Agency RN (registered nurse) CM (case manager) O. Funding Agency RN CM O told Surveyor Resident 11's gait and balance were unstable and Resident 11 utilized his/her wheelchair when s/he left his/her own room. Funding Agency RN CM O said another funding agency case manager was visiting a different resident at the facility on 04/10/2026 and noticed Resident 11 had an injury located near Resident 11's left eye. Funding Agency RN CM O said that case manager notified Resident 11's funding agency case manager team of the injury on that same date. Funding Agency RN CM O said the facility did not report this injury to his/her case management team, as was expected, until the funding agency case management team contacted Previous Administrator I. Funding Agency RN CM O told Surveyor Previous Administrator I said caregivers denied witnessing Resident 11 experiencing a fall

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N 169	Continued From page 7 and/or finding Resident 11 on the floor after an unwitnessed fall, and Nobi did not "pick up" a fall incident on the sensor or system. Funding Agency RN CM O said s/he was not sure if Resident 11 would remember or be able to communicate whether s/he had fallen or not if asked about it. On 07/23/2026 at 10:22 A.M., Surveyor conducted an interview with Resident 11's Third-party CM N. Third-party CM N told Surveyor s/he was contacted by Legal Representative P on 04/10/2026 about being contacted by Resident 11's funding agency reporting an injury near Resident 11's left eye which s/he had not been informed of by the facility. Third-party CM N said Legal Representative P asked him/her to visit Resident 11 at the facility to check on Resident 11 on Legal Representative P's behalf. Third-party CM N said s/he visited Resident 11 on 04/10/2026 and observed a fading bruise and healing laceration near Resident 11's left eye. Third-party CM N confirmed with Legal Representative P about not being informed by the facility of Resident 11's injury.	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:	{N 352}		

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{N 352}	Continued From page 8 Based on observation, interview, and record review, the provider did not ensure Resident 11 received prescribed midodrine (a medication to treat hypotension; low blood pressure) in the dosage and at intervals prescribed by a practitioner. This requirement is being cited for a sixth time. See Statement of Deficiency (SOD) RRPX13, issued on 03/18/2026, SOD RRPX12, issued on 04/15/2025, SOD RRPX11, issued on 10/01/2024, SOD Y77R14, issued 11/28/2023, and SOD Y77R11, issued on 09/01/2022. The findings include: On 05/11/2026, the department received a complaint alleging residents were not receiving medications in the dosage and at intervals prescribed by a practitioner. On 05/11/2026, Surveyor received email documentation between Resident 11's Third-party CM N and Resident 11's Funding Agency RN (registered nurse) CM (case manager) O dated 05/01/2026. The documentation included, "[Resident 11's funding agency case management team was] aware of the missed medications for March and April, which [Funding Agency RN CM O] have spoken with [Previous Agency Nurse J], [Previous Administrator I], and [Resident 11's funding case management team's] Quality Department about. [Previous Agency Nurse J and Previous Administrator I] did not give [Resident 11's funding agency case management team] a real reason why the medications were missed, yet someone reported their [sic] was a "glitch" in their system at some point. A "glitch" wouldn't [sic; would not] account for this, considering other meds [medications] were given	{N 352}		

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at the same time. [Resident 11's funding case management team's] Quality Department has placed a hold on all new [funding agency] recipients admitting to the facility due to these concerns. [Funding Agency RN CM O] did not realize [Resident 11] was receiving the midodrine outside of order parameters; that is a whole other issue, of which [Funding Agency RN CM O] will update [Funding Agency RN CM O's supervisor], [Previous Administrator I], and [Resident 11's funding case management team's] Quality Dept. [department]. In the meantime, [Resident 11's funding agency case management team] continue to request MARS [medication administrator records] and will follow up with the facility..."

Email documentation between Funding Agency RN CM O and Previous Administrator I dated 05/01/2026 included, "[Funding Agency RN CM O] am following up on the concerns related to [Resident 11's] March and April medication administration. It has been discovered that on numerous occasions, [Resident 11] was being given [his/her] midodrine when the medication should have been held/not administered, per blood pressure parameter orders. This occurred 29 times in March [2026] and 41 times in April [2026]. Midodrine is to be held if [his/her] systolic blood pressure is greater than 110. Caregivers are administering the medication without acknowledging [his/her] blood pressure, which is dangerous and against medication pass regulations. Please advise on the facility's next course of action regarding this concern."

Previous Administrator I's responding email on 05/01/2026 to Funding Agency RN CM O included, "Thank you for following up. This is concerning to hear. [Previous Administrator I] have ensured that all of my med techs [caregivers responsible for medication administration] are

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{N 352}	Continued From page 10 educated on this matter moving forward. [Previous Administrator I] will also investigate this further and keep you informed of what [Previous Administrator I] discover." Email documentation from Previous Administrator I to Funding Agency RN CM O dated 05/04/2026 included, "After further review, [the facility] identified that [the facility's] med techs were not documenting appropriately and were not following proper procedures. [Resident 11's] blood pressure was being checked, and midodrine was not administered when [his/her] systolic blood pressure is greater than 110, but this was not documented correctly. All med techs have been made aware of this issue and will receive additional training to ensure proper documentation and adherence to protocol in this situation." On 05/19/2026, Surveyor received email documentation from Funding Agency RN CM O to [Previous Administrator I] dated 05/18/2026 including, "Following up on [Resident 11's] MAR again." The email included, "All med passers are not holding the midodrine or documenting that it has been held per MD [physician/practitioner] order parameters. When can [Resident 11's funding agency case management team] expect compliance with this medication?" An email from Funding Agency RN CM O to Third-Party CM N dated 05/18/2026 included, "[Resident 11's funding agency case management team] continue to see issues with [Resident 11's] midodrine medication administration. [Previous Administrator I] reports med passers have been trained and educated on when to give/hold this medication and how to document it, however [Resident 11's funding agency case management team] continue to see that the medication was either given when it should have been held or has not been documented is has been held."	{N 352}		

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{N 352}	Continued From page 11 On 07/01/2026, Surveyor received documentation from Third-party CM N to Regional Director of Operations S, Facility Nurse L, and Funding Agency RN CM O dated 07/01/2026 including, "[Third-party CM N] know last month [Funding Agency RN CM O] spoke to [Regional Director of Operations S] regarding concerns about [Resident 11's] continuing medication errors. After reviewing [his/her] June MAR, [Third-party CM N and Resident 11's funding agency case management team] again identified a number of concerns." On 07/15/2026 at 8:30 A.M. and 6:38 P.M., Surveyor conducted an interview with Interim Administrator K. Interim Administrator K told Surveyor s/he had been the interim administrator of this facility for approximately 1.5 weeks following Previous Administrator I's termination on 06/26/2026. Interim Administrator K told Surveyor Facility Nurse L's, a registered nurse, hire date was 05/04/2026 and s/he filled the director of wellness position following Previous Agency Nurse J's termination on 05/26/2026. On 07/15/2026, Surveyor reviewed Resident 11's record, as requested and provided by Facility Nurse L. Resident 11's diagnoses included dementia and hypotension (low blood pressure). Resident 11's unsigned ISP dated 04/12/2026 included, "Medication: Full assist." Resident 11's May 2026 and June 2026 MARs included, "Midodrine HCL 5 mg [milligram] tablet. Take 1 tablet by mouth twice daily for low B/P [blood pressure], if systolic B/P > [greater than] 110 hold midodrine." Resident 11's MARs included, "Vitals required." Within Resident 11's May 2026 MAR, caregivers documented 21 morning doses of Midodrine and 18 afternoon doses were administered to Resident 11 when	{N 352}		

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Resident 11's systolic blood pressure was documented as being over 110. Within Resident 11's June 2026 MAR, caregivers documented 8 morning doses of Midodrine and 5 afternoon doses were administered to Resident 11 when Resident 11's systolic blood pressure was documented as being over 110. Resident 11's midodrine was discontinued from Resident 11's June 2026 MAR on 06/12/2026.
Resident 11's June 2026 and July 2026 MARs include documentation Resident 11's systolic blood pressure fell below 110 on 8 days out of the 33 days between 06/13/2026 and 07/16/2026, and Resident 11's blood pressure was not documented on 3 of those 33 days.

On 07/15/2026 at 11:15 A.M., Facility Licensed Practical Nurse (LPN) R told Surveyor s/he was unaware Resident 11 ever had issues with low blood pressure. Facility LPN R said s/he was not typically at the facility for the morning medication pass, so s/he did not know specifics about Resident 11's blood pressure or midodrine medication. In review of the facility's employee list received from Interim Administrator K, Facility LPN R's date of hire at the facility was 02/09/2026.

On 07/15/2026 at 12:25 P.M., Facility Nurse L told Surveyor Resident 11 did have midodrine ordered for hypotension but it had been discontinued in June 2026 related to Resident 11's systolic blood pressure often greater than 110, per practitioner's parameters. Facility Nurse L said caregivers were to continue to take Resident 11's blood pressure daily to ensure Resident 11's systolic blood pressure did not "creep back down [less than 110]."

On 07/15/2026 at 5:00 P.M., Facility Nurse L told

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AUBERGE AT BROOKFIELD A MEMORY CARE COMM	1105 DAVIDSON RD BROOKFIELD, WI 53045

(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 352}	Continued From page 13 Surveyor Resident 11's MARs were to be sent to Resident 11's funding agency case management team at the end of every month regarding concerns with Resident 11's medication administration. Facility Nurse L told Surveyor Resident 11's funding agency case management team had been communicating with Previous Administrator I prior to his/her termination regarding concerns with Resident 11's medication administration, including midodrine. Facility Nurse L said s/he reviewed Resident 11's midodrine bubble packs [unit dose medication delivery system] and Resident 11's MARs after s/he had completed new hire training in May 2026. Facility Nurse L said it was hard to tell for sure if Resident 11's midodrine was administered as prescribed, as the some of the midodrine remained in the bubble pack on dates it was documented as given. Facility Nurse L said there were times when the midodrine was not in the bubble pack on dates it was documented as being held or not given. Facility Nurse L said s/he discussed Resident 11's medication administration with the caregivers responsible for administering his/her midodrine and some said they sometimes popped the midodrine out of the bubble pack and wasted/destroyed the pill if his/her systolic blood pressure was over 110. Facility Nurse L said some medication passers told him/her they documented administration of Resident 11's midodrine just because they took his/her blood pressure, even if Resident 11's systolic blood pressure was over 110. Facility Nurse L said some medication passers told him/her they were unable to document "DNG" or "drug not given" within the electronic MAR because of a "glitch" in the system. Facility Nurse L told Surveyor s/he did not document his/her observations, interviews, and/or findings related to reviewing Resident 11's MARs and bubble	{N 352}		

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{N 352}	Continued From page 14 packs related to midodrine administration. On 07/22/2026 at 3:17 P.M., Surveyor conducted an interview with Funding Agency RN CM O regarding Resident 11's midodrine order and administration. Funding Agency RN CM O said Resident 11's funding agency case management team collected Resident 11's MARs from the facility at the end of each month for a few months related to concerns with medication administration for Resident 11 and some of their other resident members. Funding Agency RN CM O said s/he identified the facility caregivers responsible for administering Resident 11's medications were documenting administration of his/her midodrine outside of that medications prescribed parameters. Funding Agency RN CM O said Resident 11's gait and balance can be unstable and s/he had allegedly experienced at least 1 unwitnessed fall between March 2026 and June 2026. Funding Agency RN CM O said the funding case management team also had concerns with employee turnover at the facility including the facility's management during this time frame. Funding Agency RN CM O said Previous Administrator I communicated the facility was working on caregiver training regarding medication administration and documentation. Funding Agency RN CM O said s/he sent ongoing communication regarding concerns with Resident 11's midodrine to Previous Administrator I but s/he did not always respond in a timely manner. Funding Agency RN CM O said s/he reached out to Regional Director of Operations S, who was assisting the licensee's other facility within the region, when Previous Administrator I stopped responding to Funding Agency RN CM O on or about 05/18/2026. Funding Agency RN CM O said Regional Director of Operations S set up a meeting with Previous Administrator I and Facility	{N 352}		

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{N 352}	Continued From page 15 Nurse L. Funding Agency RN CM O said Facility Nurse L told him/her Facility Nurse L was under the impression there was a "glitch" in the electronic MAR documentation system, some caregivers were not able to document when a medication was not given or held. Funding Agency RN CM O said this explanation was hard to believe when it was clear caregivers were able to document "DNG" or "drug not given" within Resident 11's MAR. Funding Agency RN CM O said Facility Nurse L later communicated s/he had discussed Resident 11's midodrine with Resident 11's nurse practitioner and it was decided to discontinue it based on Resident 11's systolic blood pressure being consistently documented as being over the 110 parameter. Funding Agency RN CM O said Resident 11's funding agency case management team continues to be concerned with the discontinuance of Resident 11's midodrine as the facility's documentation of Resident 11's daily blood pressure documentation shows that Resident 11's systolic blood pressure continues to fluctuate lower than 110 and/or had not been documented since the medication's discontinuance on 06/12/2026. On 07/15/2026 at approximately 6:38 P.M., Interim Administrator K told Surveyor s/he was aware of the facility's past noncompliance including medication administration. Interim Administrator K said s/he would be working to correct this noncompliance.	{N 352}		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental	N 381		

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N 381	Continued From page 16 condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure an assessment was completed and documented within Resident 8's record related to Resident 8's needs, abilities, and physical and mental condition before admitting Resident 8 to the facility. Following Resident 8's admission to the facility on 01/31/2026, Resident 8 exhibited progressive, aggressive behavior towards others, including multiple violent, physical altercations with residents. The findings include: On 07/15/2026 at 8:30 A.M. and 6:38 P.M., Surveyor conducted an interview with Interim Administrator K. Interim Administrator K told Surveyor s/he had been the interim administrator of this facility for approximately 1.5 weeks following Previous Administrator I's termination on 06/26/2026. Interim Administrator K told Surveyor Facility Nurse L's, a registered nurse, hire date was 05/04/2026 and s/he filled the director of wellness position following Previous Agency Nurse J's termination on 05/26/2026.	N 381		

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N 381	Continued From page 17 On 07/15/2026 at 9:10 A.M., Surveyor conducted an interview with Facility Nurse L regarding Resident 8. Facility Nurse L told Surveyor Resident 8 had a history of physically aggressive behavior toward other residents and resistance to personal cares. Facility Nurse L said Resident 8 had been provided with 1: (to) 1 supervision 24 hours per day and a 30-day involuntary discharge notice following an incident of aggression toward another resident on 06/21/2026. On 07/15/2026 at 10:21 A.M., Surveyor observed Resident 8 ambulating without assistance near his/her own room with Caregiver M. Caregiver M told Surveyor s/he was providing 1:1 supervision for Resident 8. On 07/15/2026 at 11:15 A.M., Facility Licensed Practical Nurse (LPN) R told Surveyor s/he recalled Resident 8 entered Resident 13' and Resident 14's shared room without invitation after Resident 8 moved into the facility. Facility LPN R said Resident 13 yelled at Resident 8 and Resident 8 left their room. Resident 8's interaction with Resident 13 and Resident 14 was not documented within Resident 8's incident reports and/or progress notes provided to Surveyor. On 07/15/2026, Surveyor reviewed Resident 8's record, as requested and provided by Facility Nurse L. Resident 8 was admitted to the facility on 01/31/2026 with diagnoses including a combination of Alzheimer's disease and vascular dementia. At 4:41 P.M., Facility Nurse L told Surveyor there was no assessment completed and documented before Resident 8 was admitted to the facility within Resident 8's record. Facility Nurse L said	N 381		

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there was no documentation within Resident 8's progress notes until 02/19/2026, including any documentation regarding a pre-admission assessment for Resident 8.
At approximately 5:00 P.M., Facility Nurse L provided Surveyor with Resident 8's annual "Medicare Wellness Visit" dated 09/26/2025, documented approximately 4 months prior to Resident 8's admission to the facility. Facility Nurse L this document was the only document within Resident 8's record related to Resident 8's pre-admission information. The documentation included, "Pre-existing cognitive issues - stable." The documentation included, "[Resident 8] lives in the [local area] and has a 24-hour live-in caregiver. [His/her] last neurologist appointment was in 08/2025, during which [his/her] Namenda [memantine; dementia medication] dosage was increased." The documentation included, "There have been no changes in behavior, agitation, or irritability."
Resident 8's incident report dated 03/14/2026 at 3:00 P.M. included, "[Resident 9] was attempting to help [Resident 8] find [his/her] room, as [s/he] had wandered into the room next door. [Resident 9] tried to lead [him/her] to [his/her] room when [Resident 8] punched [Resident 9] in the face and began punching [Resident 9] in the chest. Residents were separated by witnessing staff. [Resident 8's Legal Representative T] notified of event and denied transfer to hospital. 911 notified and came out to assess the situation. [Resident 9] did not retaliate, so [Resident 8] was untouched. [Resident 8] placed on frequent checks and kept away from other residents."
Resident 8's progress note dated 03/23/2026 at 2:51 P.M. by Previous Agency Nurse J included, "[Resident 8] was in [his/her] neighbor's room, lying in [his/her] bed. Neighbor's POA [power of attorney] asked staff to remove [Resident 8] from

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the room and [Resident 8] started swinging and grabbed [his/her] arm. [S/he] stepped back and [Resident 8] released [his/her] arm. Staff removed [Resident 8] from the room and [Resident 8] continued to swing at staff...Psych NP [nurse practitioner] notified."
Resident 8's incident report dated 05/31/2026 at 11:45 P.M. included, "[Resident 8] entered [Resident 10's] room. When [Resident 10] made attempts to get [Resident 8] to leave, [Resident 8] struck [Resident 10] several times and pushed [Resident 10] to the floor. [Resident 10] got back up and again made attempts to get [Resident 8] to leave. [Resident 8] again made attempts to strike [Resident 10] and again pushed [Resident 10] to where [Resident 10] fell to the floor and [Resident 8] also fell landing on top of [Resident 10]." The report documentation included, "Caregiver heard shouting from the room and when entering [the room] found [Resident 10] standing by bed and [Resident 8] on floor." In the "action taken" section of the report the documentation included, "06/01/2026 [midnight] assisted [Resident 8] to standing position, diverted/redirected [residents] involved in altercation, escorted [Resident 8] to apartment [room]. [Resident 8] was monitored every 2 hours throughout the night."
Resident 8's progress note dated 06/18/2026 at 4:01 P.M. by Facility LPN R included, "[Resident 8] hit another resident in the face today. [Resident 8] is on 15-minute checks and assigned to one on one staff for safety of [him/her] and other residents. [Legal Representative T] was notified."
Resident 8's incident report dated 06/21/2026 at 5:45 A.M. included, "[Resident 8] was found entering [Resident 10's] room which [Resident 8] caused harm to [Resident 10]. [Resident 8] is very aggressive and is strong and always resist

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N 381	Continued From page 20 [sic] with staff in these type [sic] of situations. [Resident 8] will punch, kick, spit, do whatever [s/he] has to continue to show [his/her] rage. [Resident 8] continues to prey on our [residents of the opposite sex] which a lot of them are complaining and is [sic] scared to be around [him/her]. [Resident 8] is sweet at time [sic] but once [s/he] is left alone with a [person/resident of the opposite sex] [Resident 8] get to [sic] touchy and controlling. [Resident 8] has a small cut above [his/her] eye from fighting with [Resident 10]. [Resident 10] has a bloody nose and mouth." The documentation included, "06/21/2026 at 6:00 A.M...separated residents and put [Resident 8] on 24/7 1 on 1 care." On 07/15/2026 at approximately 6:38 P.M., Surveyor conducted an interview with Interim Administrator K and Facility Nurse L. Interim Administrator K told Surveyor s/he would ensure assessments of prospective residents would be completed and documented within the resident record to best ensure complete information was received, including information regarding behaviors, to gain a clear picture of that resident's needs prior to the resident's admittance to the facility. Interim Administrator K said Facility Nurse L would be completing all pre-admission assessments moving forward. Facility Nurse L said s/he "takes time with pre-admission assessments" in an attempt to receive accurate information about the resident. Facility Nurse L said s/he would be utilizing a pre-admission assessment form for documentation that would be included within the resident's record. Facility Nurse L said Resident 8 was a wanderer throughout the facility and s/he responded to triggers from other residents, especially residents of the opposite sex.	N 381		

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N 381	Continued From page 21 Summary: The provider did not ensure an assessment was completed and documented within Resident 8's record related to Resident 8's needs, abilities, and physical and mental condition before admitting Resident 8 to the facility. Cross Reference: N0385 DHS 83.35(2) Temporary Service Plan N0426 DHS 83.38(1)(b) Supervision	N 381		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure a written, temporary service plan was prepared and implemented to meet the needs of Resident 8 until a comprehensive individual service plan was developed and implemented. Following Resident 8's admission to the facility on 01/31/2026, no service plan, including a temporary service plan, was developed for Resident 8 until a comprehensive plan was developed and documented on 04/10/2026, which was not signed by Resident 8's Legal Representative T until 06/12/2026. Following Resident 8's admission to the facility, Resident 8 exhibited progressive, aggressive behavior towards others, including multiple violent, physical altercations with residents,	N 385		

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experienced a urinary tract infection requiring antibiotic medication and fluids to be encouraged, and experienced psychotropic medication changes.

The findings include:

On 07/15/2026 at 8:30 A.M. and 6:38 P.M., Surveyor conducted an interview with Interim Administrator K. Interim Administrator K told Surveyor s/he had been the interim administrator of this facility for approximately 1.5 weeks following Previous Administrator I's termination on 06/26/2026. Interim Administrator K told Surveyor Facility Nurse L's, a registered nurse, hire date was 05/04/2026 and s/he filled the director of wellness position following Previous Agency Nurse J's termination on 05/26/2026.

On 07/15/2026 at 9:10 A.M., Surveyor conducted an interview with Facility Nurse L regarding Resident 8. Facility Nurse L told Surveyor Resident 8 had a history of physically aggressive behavior toward other residents and resistance to personal cares. Facility Nurse L said Resident 8 had been provided with 1: (to) 1 supervision 24 hours per day and a 30-day involuntary discharge notice following an incident of aggression toward another resident on 06/21/2026.

On 07/15/2026 at 10:21 A.M., Surveyor observed Resident 8 ambulating without physical assistance near his/her own room with Caregiver M. Caregiver M told Surveyor s/he was providing 1:1 supervision for Resident 8.

On 07/15/2026 at 11:15 A.M., Facility Licensed Practical Nurse (LPN) R told Surveyor s/he recalled Resident 8 entered Resident 13' and Resident 14's shared room without invitation after

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Resident 8 moved into the facility. Facility LPN R said Resident 13 yelled at Resident 8 and Resident 8 left their room.

On 07/15/2026, Surveyor reviewed Resident 8's record, as requested and provided by Facility Nurse L. Resident 8 was admitted to the facility on 01/31/2026 with diagnoses including a combination of Alzheimer's disease and vascular dementia.
At 4:41 P.M., Facility Nurse L told Surveyor there was no assessment completed and documented before Resident 8 was admitted to the facility within Resident 8's record. Facility Nurse L said there was no documentation within Resident 8's progress notes until 02/19/2026.
At approximately 5:00 P.M., Facility Nurse L provided Surveyor with Resident 8's annual "Medicare Wellness Visit" dated 09/26/2025, documented approximately 4 months prior to Resident 8's admission to the facility. Facility Nurse L this document was the only document within Resident 8's record related to Resident 8's pre-admission information. The documentation included, "Pre-existing cognitive issues - stable." The documentation included, "[Resident 8] lives in the [local area] and has a 24-hour live-in caregiver. [His/her] last neurologist appointment was in 08/2025, during which [his/her] Namenda [memantine; dementia medication] dosage was increased." The documentation included, "There have been no changes in behavior, agitation, or irritability."
Resident 8's progress notes dated 03/10/2026 at 11:33 A.M. documented by Previous Agency Nurse J. The note included, "Routine psych visit. GDR [gradual dose reduction of] Seroquel to 25 mg [from 50 mg] BID."
Resident 8's incident report dated 03/14/2026 at 3:00 P.M. included, "[Resident 9] was attempting

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to help [Resident 8] find [his/her] room, as [s/he] had wandered into the room next door. [Resident 9] tried to lead [him/her] to [his/her] room when [Resident 8] punched [Resident 9] in the face and began punching [Resident 9] in the chest. Residents were separated by witnessing staff. [Resident 8's Legal Representative T] notified of event and denied transfer to hospital. 911 notified and came out to assess the situation. [Resident 9] did not retaliate, so [Resident 8] was untouched. [Resident 8] placed on frequent checks and kept away from other residents."
This incident report included, "Care plans adjusted for change in level of care needs. [Previous Agency Nurse J]. 03/16/2026 12:46 P.M." A progress note dated 03/16/2026 at 12:39 P.M. by Previous Agency Nurse J included, "[Resident 8] was placed on frequent checks and kept away from other residents."
Resident 8's unsigned individual service plan [ISP] dated 03/16/2026 included, "Combative/Aggressive Behaviors: Assistance needed with combative/aggressive behaviors: PERSONALIZE." This unsigned ISP included, "Impaired Recall: Assistance needed with impaired recall - recent or distant events: PERSONALIZE." This unsigned ISP included, "Agitation: Assistance needed with agitation: PERSONALIZE." This unsigned ISP did not include documentation to further "personalize" interventions related the areas identified. This unsigned ISP did not include any other documented areas including Resident 8's needs, cares, interventions, medications, and/or the ordered gradual dose reduction approximately 4 days prior to the incident on 03/14/2026. This unsigned ISP was not a complete ISP.
At 4:14 P.M., Facility Nurse L told Surveyor Resident 8's record did not contain any other ISP, including a complete ISP, until an ISP was signed

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N 385	Continued From page 25 on 06/12/2026 by Legal Representative T. Resident 8's progress note dated 03/23/2026 at 2:51 P.M. by Previous Agency Nurse J included, "[Resident 8] was in [his/her] neighbor's room, lying in [his/her] bed. Neighbor's POA [power of attorney] asked staff to remove [Resident 8] from the room and [Resident 8] started swinging and grabbed [his/her] arm. [S/he] stepped back and [Resident 8] released [his/her] arm. Staff removed [Resident 8] from the room and [Resident 8] continued to swing at staff...Psych NP [nurse practitioner] notified." Resident 8's progress note dated 03/23/2026 at 6:07 P.M. by Facility LPN R included, "[Resident 8's] Seroquel will be increased to 50 mg TID [three times daily]." Resident 8's nurse practitioner's "orders/communication" documentation dated 05/20/2026 included, "Acute visit: UTI [urinary tract infection] concerns. Urinating [and] defecating [in] odd places. [Increased] frequency. Confusion, unclear speech, more tired. Start [antibiotic medication twice daily for 14 days]." The documentation included, "Encourage fluids." A complete ISP was not documented at this time in which to include this change in Resident 8's condition. Resident 8's nurse practitioner's "orders/communication" documentation dated 05/21/2026 included, "Monitor behaviors - reassess need of med [medication] changes after few days of antibiotic [medication]." Resident 8's incident report dated 05/31/2026 at 11:45 P.M. included, "[Resident 8] entered [Resident 10's] room. When [Resident 10] made attempts to get [Resident 8] to leave, [Resident 8] struck [Resident 10] several times and pushed [Resident 10] to the floor. [Resident 10] got back up and again made attempts to get [Resident 8] to leave. [Resident 8] again made attempts to	N 385		

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strike [Resident 10] and again pushed [Resident 10] to where [Resident 10] fell to the floor and [Resident 8] also fell landing on top of [Resident 10]." The report documentation included, "Caregiver heard shouting from the room and when entering [the room] found [Resident 10] standing by bed and [Resident 8] on floor." In the "action taken" section of the report the documentation included, "06/01/2026 [midnight] assisted [Resident 8] to standing position, diverted/redirected [residents] involved in altercation, escorted [Resident 8] to apartment [room]. [Resident 8] was monitored every 2 hours throughout the night." This incident report included, "Care plans adjusted for change in level of care needs" and "set alert charting" [Facility Nurse L] 06/01/2026 5:06 P.M." This incident report included, "Stayed in community. [Legal Representative T] did not want [Resident 8] sent out [of facility]. Medication changes made." A self-report received by the department from the facility related to this incident on 06/02/2026 included, "On 06/01/2026, the Nobi [an AI (artificial intelligence) fall detection system] video associated with the alert was reviewed by the community nurse. The video showed [Resident 8] swinging at [Resident 10] and pushing [Resident 10] to the floor. [Resident 10] then stood up and pushed [Resident 8], after which [Resident 8] pushed [Resident 10] again." The self-report included, "[Resident 8] was placed on 15-minute safety checks, and staff continue to document and monitor [his/her] behaviors."
Resident 8's progress note dated 06/02/2026 at 1:26 P.M. by Facility Nurse L included, "Follow-up for resident-to-resident altercation on 05/31/2026: [Resident 8] continues on 15 minute checks for behavior/wandering. No behaviors noted. No adverse effects from incident."
Resident 8's nurse practitioner's

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"orders/communication" documentation dated 06/03/2026 included, "Acute visit: post empirical [based on experience] treatment UTI last visit. Completed [antibiotic medication]. Altercation 05/31/2026 [with Resident 10]. Facility updated all parties [arrow to] plan in place?"
Resident 8's nurse practitioner's "orders/communication" documentation dated 06/04/2026 included, "Routine visit. Mood/behaviors: Agitated; physically aggressive" and "Monitor for need of additional interventions."
Resident 8's "initial" ISP dated 04/10/2026 and signed by Legal Representative T and Facility Nurse L on 06/12/2026 included, "Agitation: Assistance needed with agitation: [Resident 8] has potential for agitation when others are in [his/her] personal space. Resident from situation and calmly redirect..15-minute safety checks." This ISP included, "Combative/Aggressive Behaviors: Assistance needed with combative/aggressive behaviors: [Resident 8] has potential for aggression when others are in his/her personal space or trying to provide care that is unwanted. Remove resident from situation and calmly redirect." This ISP included, "Safety Checks: Additional checks. Caregiver to check on [Resident 8] every 15 minutes and assist with any observed needs. Report to nurse if resident has increased agitation or is not redirectable out of other resident's rooms." This ISP addressed Resident 8's cognitive impairment, independent ambulation and transfers, potential for falls, medication administration by caregivers, assistance needed with bathing and other personal cares/activities of daily living, and Resident 8's assistance needed with emergency response and emergency evacuation.

On 07/15/2026 at approximately 6:38 P.M., Surveyor conducted an interview with Interim

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N 385	Continued From page 28 Administrator K and Facility Nurse L. Interim Administrator K said s/he had been reaching out to resident legal representatives and/or residents to set up service plan conferences to catch up on completing resident ISPs and would continue to do so. Interim Administrator K and Facility Nurse L said Previous Administrator I had not been completing resident ISPs as required. Summary: The provider did not ensure a written, temporary service plan was prepared and implemented to meet the needs of Resident 8 until a comprehensive individual service plan was developed and implemented. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0426 DHS 83.38(1)(b) Supervision	N 385		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure supervision	N 426		

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was provided appropriate to Resident 8's needs.

Following Resident 8's admission to the facility on 01/31/2026, Resident 8 exhibited progressive, aggressive behavior towards others, including multiple violent, physical altercations with residents over the course of 5 months. Two of the most significant encounters involved Resident 8 entering Resident 10's room and physically assaulting Resident 10.

The findings include:

On 07/15/2026 at 8:30 A.M. and 6:38 P.M., Surveyor conducted an interview with Interim Administrator K. Interim Administrator K told Surveyor s/he had been the interim administrator of this facility for approximately 1.5 weeks following Previous Administrator I's termination on 06/26/2026. Interim Administrator K told Surveyor Facility Nurse L's, a registered nurse, hire date was 05/04/2026 and s/he filled the director of wellness position following Previous Agency Nurse J's termination on 05/26/2026.

On 07/15/2026 at 9:10 A.M., Surveyor conducted an interview with Facility Nurse L regarding Resident 8. Facility Nurse L told Surveyor Resident 8 had a history of physically aggressive behavior toward other residents and resistance to personal cares. Facility Nurse L said Resident 8 had been provided with 1: (to) 1 supervision 24 hours per day and a 30-day involuntary discharge notice following an incident of aggression toward another resident on 06/21/2026.

On 07/15/2026 at 10:21 A.M., Surveyor observed Resident 8 ambulating without physical assistance near his/her own room with Caregiver M. Caregiver M told Surveyor s/he was providing

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N 426	Continued From page 30 1:1 supervision for Resident 8. On 07/15/2026 at 11:15 A.M., Facility Licensed Practical Nurse (LPN) R told Surveyor s/he recalled Resident 8 entered Resident 13' and Resident 14's shared room without invitation after Resident 8 moved in to the facility. Facility LPN R said Resident 13 yelled at Resident 8 and Resident 8 left their room. Resident 8's interaction with Resident 13 and Resident 14 was not documented within Resident 8's incident reports and/or progress notes provided to Surveyor. Facility LPN R said s/he knew Resident 8 initiated 2 acts of physical aggression toward Resident 10 and 1 toward Resident 9 following his/her admission to the facility, but no other incidents. Facility LPN R told Surveyor Resident 10 had diagnoses including Huntington's disease (a brain disorder characterized by uncontrolled movements, cognitive decline, and psychiatric changes), required a Broda (specialized chair) chair for sitting in common areas related to uncontrolled movement, and was able to ambulate short distances in his/her own room. On 07/15/2026 at 11:30 A.M., Surveyor observed Resident 10 seated in a high-back wheelchair located in Bistro C of the facility. Caregiver C told Surveyor s/he was only aware of Resident 8 initiating 2 acts of physical aggression toward Resident 10 and 1 toward Resident 9 following his/her admission to the facility. Caregiver C told Surveyor Resident 9 was able to ambulate independently at all times and experienced confusion related to dementia. Caregiver C told Surveyor Resident 10 was able to ambulate independently in his/her own room and had experienced falls. Caregiver C told Surveyor Resident 10 required a high-back	N 426		

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wheelchair in the dining room for meals and when Resident 10 was in common areas of the facility.

On 07/15/2026 at 12:25 P.M., Surveyor observed Resident 9 ambulate to the dining room located at the front of the facility and required verbal cues from a caregiver where to sit for lunch.

On 07/15/2026, Surveyor reviewed Resident 8's record, as requested and provided by Facility Nurse L. Resident 8 was admitted to the facility on 01/31/2026 with diagnoses including a combination of Alzheimer's disease and vascular dementia.
At 4:41 P.M., Facility Nurse L told Surveyor there was no assessment completed and documented before Resident 8 was admitted to the facility within Resident 8's record. Facility Nurse L said there was no documentation within Resident 8's progress notes until 02/19/2026.
At approximately 5:00 P.M., Facility Nurse L provided Surveyor with Resident 8's annual "Medicare Wellness Visit" dated 09/26/2025, documented approximately 4 months prior to Resident 8's admission to the facility. Facility Nurse L this document was the only document within Resident 8's record related to Resident 8's pre-admission information. The documentation included, "Pre-existing cognitive issues - stable." The documentation included, "[Resident 8] lives in the [local area] and has a 24-hour live-in caregiver. [His/her] last neurologist appointment was in 08/2025, during which [his/her] Namenda [memantine; dementia medication] dosage was increased." The documentation included, "There have been no changes in behavior, agitation, or irritability."
Resident 8's "progress notes" included a note dated 02/19/2026 at 1:43 P.M. documented by Facility LPN R. The note included, "Established

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care visit from psych [psychiatric provider]. Medication changes were made. Buspar [psychotropic, anxiety medication] 10 mg [milligrams] take BID [twice daily] morning and HS [evening]. Seroquel [psychotropic, antipsychotic medication] 50 mg BID at noon and HS. Continue melatonin [sleep supplement] at HS. Continue donepezil [dementia medication] at HS. Continue memantine BID. New - lorazepam added 0.5 mg BID and for anxiety PRN [as needed]. Will monitor and update any changes."
Resident 8's progress notes dated 03/10/2026 at 11:33 A.M. documented by Previous Agency Nurse J. The note included, "Routine psych visit. GDR [gradual dose reduction of] Seroquel to 25 mg [from 50 mg] BID."
Resident 8's incident report dated 03/14/2026 at 3:00 P.M. included, "[Resident 9] was attempting to help [Resident 8] find [his/her] room, as [s/he] had wandered into the room next door. [Resident 9] tried to lead [him/her] to [his/her] room when [Resident 8] punched [Resident 9] in the face and began punching [Resident 9] in the chest. Residents were separated by witnessing staff. [Resident 8's Legal Representative T] notified of event and denied transfer to hospital. 911 notified and came out to assess the situation. [Resident 9] did not retaliate, so [Resident 8] was untouched. [Resident 8] placed on frequent checks and kept away from other residents."
This incident report included, "Care plans adjusted for change in level of care needs. [Previous Agency Nurse J]. 03/16/2026 12:46 P.M." A progress note dated 03/16/2026 at 12:39 P.M. by Previous Agency Nurse J included, "[Resident 8] was placed on frequent checks and kept away from other residents."
Resident 8's unsigned individual service plan [ISP] dated 03/16/2026 included, "Combative/Aggressive Behaviors: Assistance

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needed with combative/aggressive behaviors: PERSONALIZE." This unsigned ISP included, "Impaired Recall: Assistance needed with impaired recall - recent or distant events: PERSONALIZE." This unsigned ISP included, "Agitation: Assistance needed with agitation: PERSONALIZE." This unsigned ISP did not include documentation to further "personalize" interventions related the areas identified. This unsigned ISP did not include any other documented areas including Resident 8's needs, cares, interventions, medications, and/or the ordered gradual dose reduction approximately 4 days prior to the incident on 03/14/2026. This unsigned ISP was not a complete ISP.

At 4:14 P.M., Facility Nurse L told Surveyor Resident 8's record did not contain any other ISP, including a complete ISP, until an ISP was signed on 06/12/2026 by Legal Representative T.

Resident 8's progress note dated 03/23/2026 at 2:51 P.M. by Previous Agency Nurse J included, "[Resident 8] was in [his/her] neighbor's room, lying in [his/her] bed. Neighbor's POA [power of attorney] asked staff to remove [Resident 8] from the room and [Resident 8] started swinging and grabbed [his/her] arm. [S/he] stepped back and [Resident 8] released [his/her] arm. Staff removed [Resident 8] from the room and [Resident 8] continued to swing at staff...Psych NP [nurse practitioner] notified."

Resident 8's progress note dated 03/23/2026 at 6:07 P.M. by Facility LPN R included, "[Resident 8's] Seroquel will be increased to 50 mg TID [three times daily]."

Resident 8's nurse practitioner's "orders/communication" documentation dated 05/20/2026 included, "Acute visit: UTI [urinary tract infection] concerns. Urinating [and] defecating [in] odd places. [Increased] frequency. Confusion, unclear speech, more tired. Start

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[antibiotic medication twice daily for 14 days]." The documentation included, "Encourage fluids." A complete ISP was not documented at this time in which to include this change in Resident 8's condition.

Resident 8's nurse practitioner's "orders/communication" documentation dated 05/21/2026 included, "Monitor behaviors - reassess need of med [medication] changes after few days of antibiotic [medication]." The order to monitor Resident behaviors was not addressed within Resident 8's progress notes.

Resident 8's incident report dated 05/31/2026 at 11:45 P.M. included, "[Resident 8] entered [Resident 10's] room. When [Resident 10] made attempts to get [Resident 8] to leave, [Resident 8] struck [Resident 10] several times and pushed [Resident 10] to the floor. [Resident 10] got back up and again made attempts to get [Resident 8] to leave. [Resident 8] again made attempts to strike [Resident 10] and again pushed [Resident 10] to where [Resident 10] fell to the floor and [Resident 8] also fell landing on top of [Resident 10]." The report documentation included, "Caregiver heard shouting from the room and when entering [the room] found [Resident 10] standing by bed and [Resident 8] on floor." In the "action taken" section of the report the documentation included, "06/01/2026 [midnight] assisted [Resident 8] to standing position, diverted/redirected [residents] involved in altercation, escorted [Resident 8] to apartment [room]. [Resident 8] was monitored every 2 hours throughout the night." This incident report included, "Care plans adjusted for change in level of care needs" and "set alert charting" [Facility Nurse L] 06/01/2026 5:06 P.M." This incident report included, "Stayed in community. [Legal Representative T] did not want [Resident 8] sent out [of facility]. Medication changes made." A

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self-report received by the department from the facility related to this incident on 06/02/2026 included, "On 06/01/2026, the Nobi [an AI (artificial intelligence) fall detection system] video associated with the alert was reviewed by the community nurse. The video showed [Resident 8] swinging at [Resident 10] and pushing [Resident 10] to the floor. [Resident 10] then stood up and pushed [Resident 8], after which [Resident 8] pushed [Resident 10] again." The self-report included, "[Resident 8] was placed on 15-minute safety checks, and staff continue to document and monitor [his/her] behaviors." This self-report included documentation of "Staff Development Program Attendance Record" including "Topic: [Resident 8] aggressive behaviors 15 minute checks." This attendance record did not include a date of presentation.
Resident 8's progress note dated 06/01/2026 at 1:24 P.M. by Facility Nurse L included, "[Resident 8] had resident to resident altercation 05/31/2026 at approximately 11:50 P.M." The documentation included, "Staff monitored [Resident 8] throughout the night to ensure [s/he] did not enter any rooms...NOR [new order received] to increase both Lorazepam dose at HS and [Seroquel] to 75 mg TID."
Resident 8's progress note dated 06/02/2026 at 1:26 P.M. by Facility Nurse L included, "Follow-up for resident to resident altercation on 05/31/2026: [Resident 8] continues on 15 minute checks for behavior/wandering. No behaviors noted. No adverse effects from incident."
Resident 8's nurse practitioner's "orders/communication" documentation dated 06/03/2026 included, "Acute visit: post empirical [based on experience] treatment UTI last visit. Completed [antibiotic medication]. Altercation 05/31/2026 [with Resident 10]. Facility updated all parties [arrow to] plan in place?"

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(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 426	Continued From page 36 Resident 8's nurse practitioner's "orders/communication" documentation dated 06/04/2026 included, "Routine visit. Mood/behaviors: Agitated; physically aggressive" and "Monitor for need of additional interventions." Resident 8's "initial" ISP dated 04/10/2026 and signed by Legal Representative T and Facility Nurse L on 06/12/2026 included, "Agitation: Assistance needed with agitation: [Resident 8] has potential for agitation when others are in [his/her] personal space. Remove resident from situation and calmly redirect..15 minute safety checks." This ISP included, "Combative/Aggressive Behaviors: Assistance needed with combative/aggressive behaviors: [Resident 8] has potential for aggression when others are in his/her personal space or trying to provide care that is unwanted. Remove resident from situation and calmly redirect." This ISP included, "Safety Checks: Additional checks. Caregiver to check on [Resident 8] every 15 minutes and assist with any observed needs. Report to nurse if resident has increased agitation or is not redirectable out of other resident's rooms." Resident 8's nurse practitioner's "orders/communication" documentation dated 06/18/2026 included, "Routine visit: Med review: No changes, recent changes done. Monitor and update if aggression arises." Resident 8's progress note dated 06/18/2026 at 4:01 P.M. by Facility LPN R included, "[Resident 8] hit another resident in the face today. [Resident 8] is on 15-minute checks and assigned to one-on-one staff for safety of [him/her] and other residents. [Legal Representative T] was notified." On 07/15/2026 at 2:45 P.M., Facility Nurse L told Surveyor there was no documentation of 15-minute checks retained for Resident 8.	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017799	A. BUILDING: _____ B. WING _____	R-C 07/23/2026

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AUBERGE AT BROOKFIELD A MEMORY CARE COMM	1105 DAVIDSON RD BROOKFIELD, WI 53045

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N 426	Continued From page 37 Facility Nurse L said Previous Administrator I told him/her on 06/21/2026 Previous Administrator I was unable to locate any documented 15-minute checks of behavior monitoring and/or interventions for Resident 8. Resident 8's incident report dated 06/21/2026 at 5:45 A.M. included, "[Resident 8] was found entering [Resident 10's] room which [Resident 8] caused harm to [Resident 10]. [Resident 8] is very aggressive and is strong and always resist [sic] with staff in these type [sic] of situations. [Resident 8] will punch, kick, spit, do whatever [s/he] has to continue to show [his/her] rage. [Resident 8] continues to prey on our [residents of the opposite sex] which a lot of them are complaining and is [sic] scared to be around [him/her]. [Resident 8] is sweet at time [sic] but once [s/he] is left alone with a [person/resident of the opposite sex] [Resident 8] get to [sic] touchy and controlling. [Resident 8] has a small cut above [his/her] eye from fighting with [Resident 10]. [Resident 10] has a bloody nose and mouth." The documentation included, "06/21/2026 at 6:00 A.M...separated residents and put [Resident 8] on 24/7 1 on 1 care." A self-report received by the department from the facility related to this incident on 06/22/2026 included, "Upon reviewing the Nobi footage, it was observed that [Resident 8] physically assaulted [Resident 10]. The footage shows [Resident 8] punching and kicking [Resident 10] in the face multiple times. During the altercation, both residents fell to the ground. The incident represents the third documented resident-to-resident assault involving [Resident 8] [inaccurate based on record review] and the second documented incident in which [Resident 10] was the victim." The self-report documentation included, "[Legal Representative T] was notified of the incident and transported	N 426		

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N 426	Continued From page 38	N 426		

[Resident 8] to the hospital for evaluation. [Resident 10] was assessed by hospice following the altercation. Due to the ongoing safety concerns and history of resident-to-resident aggression, [Resident 8] was immediately upgraded from 15-minute safety checks to continuous 24/7 one-on-one supervision provided by the community."
Resident 8's progress note dated 06/23/2026 at 3:09 P.M. by Facility Nurse L included, "Late Entry: [Resident 8] had an altercation with [Resident 10] on 06/21/2026 at approximately 6:15 A.M...[Legal Representative T] was notified and came to facility immediately and took [Resident 8] to ER [emergency room] for eval [evaluation]. [Resident 8] returned from ER with no new findings. 1:1 caregiver initiated upon return from ER."
Resident 8's unsigned ISP dated 06/17/2026 included, "***06/22/2026 [Resident 8] to have 1:1 caregiver at all times until further notice."

On 07/15/2026 at approximately 6:38 P.M., Surveyor conducted an interview with Interim Administrator K and Facility Nurse L. Interim Administrator K told Surveyor s/he would ensure assessments of prospective residents would be completed and documented within the resident record to best ensure complete information was received, including information regarding behaviors, to gain a clear picture of that resident's needs prior to the resident's admittance to the facility. Interim Administrator K said Facility Nurse L would be completing all pre-admission assessments moving forward. Facility Nurse L said s/he "takes time with pre-admission assessments" in an attempt to receive accurate information about the resident. Facility Nurse L said s/he would be utilizing a pre-admission assessment form for documentation that would

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N 426	Continued From page 39 be included within the resident's record. Facility Nurse L said the caregivers would be receiving education regarding resident supervision related to behaviors, and communication with management. Facility Nurse L said gradual dose reductions of psychotropic medications will be monitored by a RN, such as Facility Nurse L, including documentation of medication changes and behaviors within the resident's record. Facility Nurse L said Resident 8 was a wanderer throughout the facility and s/he responded to triggers from other residents, especially residents of the opposite sex. Summary: The provider did not ensure supervision was provided appropriate to Resident 8's needs. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0385 DHS 83.35(2) Temporary Service Plan	N 426		