STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525424	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Brookfield	18740 W Bluemound Rd Brookfield, WI 53045

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 2 (R5 and R97) of 5 residents reviewed with pressure injuries. *R5 had a history of pressure injuries and was readmitted to the facility on [DATE]. R5’s skin was not comprehensively assessed by a Registered Nurse (RN) upon readmission. On 9/6/2024, R5 was assessed by the Wound Physician and discovered to have a Stage 3 pressure injury to the right buttock, a Stage 3 pressure injury to the left buttock, and a Stage 3 pressure injury to the coccyx and treatments were initiated to the pressure injuries at that time. Surveyor observed R5 repositioning independently in bed and potentially causing shearing to the skin; R5’s Skin Integrity Care Plan had the intervention to use a draw sheet or lifting device to move R5. *R97 was readmitted to the facility after hospitalization with a Stage 3 pressure injury to the right fifth toe, no treatment was ordered for five days, and no treatment was completed to the pressure injury until one week later. Findings include: The facility policy and procedure titled “Wound Management – Wound Prevention and Treatment” dated 10/11/2024 documents: “PROVISION AND PROCEDURE: … 2. Upon admission, the resident will receive a head-to-toe skin check to identify any skin issues. An RN will assess any noted pressure injuries and complete an initial comprehensive assessment. … 5. Daily, during routine care, the Certified Nursing Assistant (CNA) will observe the resident’s skin. When abnormalities are noted, this will be communicated to the licensed nurse, and the licensed nurse will evaluate and implement a skin event if applicable. An RN will assess any noted pressure injuries and complete an initial comprehensive assessment.” 1.) R5 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, diabetes, morbid obesity, chronic respiratory failure, below the knee amputation of the right leg, above the knee amputation of the left leg, and peripheral vascular disease. R5’s Annual Minimum Data Set (MDS) assessment dated [DATE] documented R5 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R5’s Skin Integrity Care Plan was initiated on 10/19/2022 on admission. The following interventions were in place on 10/30/2023:-Encourage and assist to reposition every 2-3hrs and upon request.-Use a draw sheet or lifting device to move resident.-Bilateral grab bars to aid with independence and bed mobility. R5 had a history of skin impairment to multiple areas with previous pressure injuries and non-pressure injuries to R5's left and right buttocks and the sacrum or coccyx. R5's Skin Impairment/Wound Evaluation form dated 8/16/2024 documented that R5 had moisture associated skin damage (MASD) to the right thigh and left buttock. R5's progress note dated 8/23/2024 at 12:07 PM documented that R5 had a critical lab that was called in that morning and the Nurse Practitioner (NP) was notified of the lab result. The NP gave an order to send R5 to the hospital for evaluation. At 6:56 PM in the progress notes, nursing documented R5 was admitted to the hospital for cellulitis. On 8/29/2024 on the hospital discharge record, the physician documented R5 had a diagnosis of cellulitis to the pannus (tissue and fat that hangs down from the abdomen). No other skin alterations or wounds were documented. R5 was readmitted to the facility on [DATE]. R5’s hospital record did not document any wounds to the skin. R5's Readmissions Data Collection Tool dated 8/29/2024 and written by Licensed Practical Nurse (LPN)-V documented on the Skin Section of the form R5 had redness to the coccyx, the left buttock, and the right buttock. The areas were not measured, and no characteristics of the areas were documented, such as if the redness was blanchable or had any raised or open areas. No documentation was found of an RN assessing R5’s skin. On 9/6/2024, R5 was seen by the Wound Physician on scheduled weekly rounds. R5 had last seen the Wound Physician on 8/16/2024 prior to R5’s hospitalization. On 9/6/2024 on the Skin Impairment/Wound Evaluation form, nursing documented R5 had a Stage 3 pressure injury to the right buttock that measured 1.6 cm x 1 cm x 0.1 cm with 50% granulation tissue and 50% slough, a Stage 3 pressure injury to the left buttock that measured 1.7 cm x 0.8 cm x 0.1 cm with 100% granulation tissue, and a Stage 3 pressure injury to the coccyx that measured 2.63 cm x 0.9 cm x 0.1 cm with 100% granulation tissue. All three pressure injuries were surgically debrided by the Wound Physician and a treatment of Medihoney was initiated at that time. Surveyor noted no treatments, such as barrier cream, was in place prior to the discovery of the pressure injuries. No documentation was found of the pressure injuries being discovered prior to R5 being assessed by the Wound Physician on scheduled rounds or any notification of any skin impairment. R5’s Skin Integrity Care Plan had been revised on 9/10/2024 with documentation R5’s Stage 3 pressure injuries to the right buttock the left buttock and the coccyx were present on readmission on [DATE]. Surveyor noted R5 was readmitted to the facility on [DATE] and no comprehensive assessment had been completed or documented prior to 9/6/2024 when R5 was seen by the Wound Physician. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R5’s left buttock Stage 3 pressure injury healed on 9/13/2024 and reopened on 11/6/2024. On 8/20/2025 on the Skin Impairment/Wound Evaluation form, R5’s left buttock Stage 3 pressure injury measured 2.5 cm x 1.2 cm x 0.1 cm with 40% epithelial tissue and 60% granulation tissue. R5’s right buttock Stage 3 pressure injury healed on 10/30/2024, reopened on 11/13/2024, healed on 1/22/2025, reopened on 4/30/2025 after readmission from the hospital, healed on 6/4/2025, reopened on 6/11/2025, healed on 6/25/2025, and reopened on 7/23/2025. On 8/20/2025 on the Skin Impairment/Wound Evaluation form, R5’s right buttock Stage 3 pressure injury measured 1.5 cm x 1 cm x 0.1 cm with 100% granulation tissue. R5’s coccyx Stage 3 pressure injury healed on 10/2/2024. On 8/24/2025 at 1:04 PM, Surveyor observed R5 lying in bed on R5’s back with the head of the bed elevated at approximately 30 degrees. R5 had a pillow under the head. No other pillows or positioning devices were observed in R5’s bed or room. Surveyor asked R5 if R5 had concerns with open areas to the skin. R5 stated R5 had a pressure injury to the backside for about one year and it was tiny but just would not close up. In an interview on 8/25/2025 at 3:28 PM, Surveyor asked Wound Nurse (WN)-F if WN-F was familiar with R5. WN-F stated yes. Surveyor shared with WN-F the concern R5 was not assessed by an RN when readmitted on [DATE] and on 9/6/2024, when R5 was seen by the Wound Physician, R5 had developed three Stage 3 pressure injuries, and no treatments were in place prior to 9/6/2024 to prevent any skin breakdown. WN-F stated WN-F would see if WN-F could find any information to fill in the gaps with the assessments and treatments. On 8/26/2025 at 9:31 AM, Surveyor observed LPN-AA complete wound care to R5. R5 was lying in bed on the back with the head of the bed elevated approximately 30 degrees. R5 had a pillow under the head. No other pillows or positioning devices were observed in R5’s bed or room. LPN-AA asked R5 to roll to the left side which R5 was able to do independently by using the enabler bar on the side of the bed. R5 had a wound to the coccyx that measured approximately 2 cm x 2 cm x 0.1 cm with clean pink tissue to the wound bed. Surveyor noted documentation was of a wound to the right buttock and not the coccyx. R5 had a wound to the left buttock adjacent to the coccyx wound that measured approximately 2 cm x 2 cm x 0.1 cm with active bleeding and a pink wound base. A smaller area below the left buttock wound, appearing like a puncture wound, had serosanguineous fluid leaking out of the wound. The wound measured less than 0.5 cm x 0.5 cm, and the wound bed was not visible. R5 had excoriation to the lower right and left buttock that appeared to have barrier cream remnants still in place. A single dressing was placed over all three open areas after collagen was applied. After LPN-AA had completed the dressing change, R5 independently rolled back onto the back, lowered the head of the bed with the feet elevated, and grabbed onto the headboard with both hands and pulled so R5 was positioned at the top of the bed. R5 did not ask for assistance and no draw sheet was observed to be in place on the air mattress. Surveyor noted additional shearing may have occurred due to no assistance with positioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 8/26/2025 at 12:57 PM, Surveyor asked Director of Nursing (DON)-B what the facility protocol for assessing skin was when either a new admission comes to the facility or when a resident is readmitted to the facility. DON-B stated the nurse that is assigned to the unit does the initial skin assessment, but within 24 hours WN-F does a skin sweep as well. DON-B stated newly admitted and readmitted residents should have a skin assessment done. Surveyor shared with DON-B the concern an LPN assessed R5 on readmission documenting redness to the right buttock, left buttock, and coccyx and did not have a comprehensive skin assessment until 9/6/2024 when the Wound Physician found R5 to have three Stage 3 pressure injuries. On 8/27/2025 at 8:27 AM, Surveyor observed R5 to be lying on the back with the head of the bed elevated approximately 30 degrees with a pillow under the head. No other pillows or positioning devices were observed in R5’s bed or room. Surveyor asked R5 if staff ever put pillows behind R5’s back or hip to keep pressure off R5’s bottom or encouraged or assisted R5 to move onto the side. R5 stated no. R5 stated no one had ever offered pillows and would not have said no if they had asked. In an interview on 8/27/2025 at 8:33 AM, Surveyor asked CNA-L if R5 needed assistance with bed mobility or positioning and if R5 needed to be turned, how often would that be done. CNA-L stated CNA-L did not know because this was the first time CNA-L had worked with R5. Surveyor asked CNA-L where CNA-L would look to see how much assistance R5 needed. CNA-L stated CNA-L would ask the nurse. CNA-L talked to LPN-Q and CNA-L told Surveyor R5 should get turned every two hours with staff assistance. In an interview on 8/27/2025 at 8:36 AM, Surveyor asked CNA-BB if CNA-BB was familiar with R5. CNA-BB stated CNA-BB has worked with R5. Surveyor asked CNA-BB how much assistance R5 needed to turn in bed. CNA-BB stated R5 is able to turn independently in bed so does not need any help turning. CNA-BB stated R5 grabs onto the side bar and can put the leg over independently. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/27/2025 at 11:23 AM, Surveyor met with Director of Quality Assurance (DirQA)-CC and WN-F to discuss the concerns Surveyor had shared with WN-F and DON-B regarding R5’s readmission skin assessment and discovery of the three Stage 3 pressure injuries. DirQA-CC stated WN-F was not the wound care nurse in August 2024, so DirQA-CC was trying to help WN-F figure out what happened at that time. Surveyor shared with DirQA-CC and WN-F R5’s Skin Integrity Care Plan documented R5 came back to the facility with the Stage 3 pressure injuries on 9/2/2024 even though R5 returned on 8/29/2024. DirQA-CC stated DirQA-CC saw the documentation of the redness to the right buttock, the left buttock, and the coccyx and it was not known if the redness was blanchable or not. DirQA-CC stated DirQA-CC would have liked to see more description of the area but stated barrier cream had been ordered at that time and that would have been appropriate for redness. Surveyor noted R5 did not have any orders for barrier cream at the time of readmission. DirQA-CC provided an Unavoidable Pressure Injury Tool form completed by the physician on 11/6/2024 showing comorbidities that were causing the wound to reopen. DirQA-CC stated with modalities in place, the wound should have healed so they met with the physician to discuss what was going on with R5. Surveyor shared the concern that if R5 did have redness on readmission, the Stage 3 pressure injuries would have developed prior to the Wound Physician assessing them on 9/6/2024 and there is no documentation showing anyone reporting open areas or assessing them when found. Surveyor shared with DirQA-CC and WN-F the conversations with CNA-L and CNA-BB about repositioning; CNA-L was not aware R5 needed repositioning and CNA-BB stated R5 repositions independently. Surveyor shared the observation of no pillows or positioning devices in R5’s room and the conversation with R5 of never being positioned on the side. WN-F stated WN-F had seen pillows under R5 at times and knows R5 needs more assistance when ill and then is much more independent with bed mobility when feeling better. Surveyor shared the observation of R5 repositioning independently to boost up in bed and the concern excessive shearing was possible with no assistance of a lift sheet. No additional information was provided. 2.) R97 was readmitted to the facility on [DATE] with diagnoses of paraplegia and a pressure injury. R97 is alert and able to make his needs known.The wound assessment upon readmission on [DATE] documents, Stage 3 pressure injury of right 5th toe measuring 1.5 cm by 0.5 cm by 0.2 cm with 80% granulation and 20% slough. The physician orders do not reflect any treatment orders for the right 5th toe pressure injury. On 6/30/25, the physician orders document, wound care for right 5th toe: cleanse with normal saline, apply medihoney and calcium alginate with silver f/b (followed by) foam border dressing. Daily and PRN (as needed). The TAR (treatment administration record) for June 2025 documents wound care for right 5th toe: cleanse with normal saline, apply medihoney and calcium alginate with silver f/b (followed by) foam border dressing. Daily and PRN (as needed). The TAR has this order under the PRN orders and no daily scheduled treatment orders is documented. The June 2025 TAR indicates no treatment for the right 5th toe is completed. R97’s impaired skin integrity care plan dated 5/6/25 documents provide pressure relieving device (s): APM (alternating pressure mattress); offloading heels boots, turn and position as necessary, follow facility protocols for treatment of injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The medical record indicates on 7/2/25 Wound MD assessed the right 5th toe pressure injury and debrided the wound and now the area measures 1 cm by 1.3 cm by 0.3 cm with 60% granulation and 30% necrotic tissue and 10% tendon. The treatment for the wound remained the same. The TAR reflects the daily treatment order on 7/2/25. The 8/21/25 wound evaluation documents the right 5th toe pressure injury measures 0.8 cm by 1 cm by 0.1 cm with 100% granulation. The treatment is cleanse with normal saline, apply methylene blue foam f/b gauze border dressing; 3x/week and PRN every day shift every Mon, Wed, Fri AND as needed. On 8/27/25 at 8:34 a.m. Surveyor observed R97's treatment to the right 5th toe. Wound Nurse-F performed the treatment. No concerns were noticed with the treatment. On 8/27/25 at 8:46 a.m. Surveyor interviewed Wound Nurse-F. Surveyor asked Wound Nurse-F who is responsible for putting in treatment orders when a resident is admitted or readmitted to the facility. Wound Nurse-F stated either she or another wound nurse will do it. Wound Nurse-F stated if they are not around then the admitting nurse will do it. Surveyor explained the concern R97 was readmitted to the facility on [DATE] with the right 5th toe pressure injury and there wasn’t an order until 6/30/25 but in the TAR it was documented as PRN and it looks like a treatment wasn’t completed until 7/2/25. Wound Nurse-F stated she would look into it. On 8/27/25 at 11:41 a.m. Surveyor interviewed Wound Nurse-F again. Wound Nurse-F stated she placed the treatment order on 6/30/25. Surveyor explained no treatment was documented as being completed until 7/2/25. Wound Nurse-F stated she understood the concern and the treatment order should have been ordered and placed in the TAR on 6/27/25 and treatment should have been completed.