STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525556	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	3506 Washington Rd Kenosha, WI 53144

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, document review and facility policy review, the facility failed to ensure one of four residents reviewed for medication administration (Resident (R)1) out of eight sampled residents was free from significant medication errors when R1 was administered R8’s medications which included amiodarone (cardiac antiarrhythmic), bumetanide (diuretic), carvedilol (blood pressure), clozapine (antipsychotic), divalproex (anticonvulsant), Jardiance (diabetic), and lamotrigine (anticonvulsant). This failure resulted in the R1’s becoming lethargic, requiring hospitalization. Findings include: Review of the facility's policy titled, Medication Administration dated 11/21/17 provided by the facility revealed, Administer to the patient after verifying the resident’s identity. Follow the six rights . right patient, right medication, right dose, right time, right route, and right documentation. Identify residents by their photo in the computer. Ask his/her name. If unsure of either step listed above, verify with another staff member. Review of R1's Face Sheet located in the Face Sheet tab of the electronic medical record (EMR), revealed R1 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus with diabetic chronic kidney disease, acute respiratory failure with hypoxia, sepsis, iron deficiency anemia, metabolic encephalopathy, chronic kidney disease, dysphagia, peripheral vascular disease, personal history of transient ischemic attack (TIA), and cerebral infarction. Review of R1’s quarterly “Minimum Data Set (MDS)” located under the “MDS” tab of the EMR with an Assessment Reference Date (ARD) of 04/17/25 revealed R1 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R1 had moderate cognitive impairment. Review of R1’s “Progress notes” located under the “Prog Notes” tab of the EMR dated 05/11/25 at 9:00 AM, documented, wrong medications were given to [R1]. The resident was able to follow directions by squeezing fingers but was very lethargic and could not follow any other commands, unable to respond verbally to any questions, could not open eyes and drool running out of his mouth with deep, slow shallow respirations. Resident’s vital signs were 141/79, pulse 100, O2 Sat 95% RA, Resp 12 and BS 299. Immediately called 911 after assessment and reviewing medications given. Ambulance arrived at 0916 [9:16AM] and resident was transported to hospital. POA [Power of Attorney] called and updated on wrong medications given….On call doctor notified and gave orders to send to the hospital (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525556	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	3506 Washington Rd Kenosha, WI 53144

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of R8’s Medication Administration Record (MAR) dated 05/11/25 located under the Reports tab of the EMR revealed R8 was to be administered amiodarone (cardiac antiarrhythmic) 200 milligram (mg), bumetanide (diuretic) 0.5 mg, carvedilol (blood pressure) 3.125 mg, clozapine (antipsychotic) 25 mg, divalproex (anticonvulsant) 125 mg, Jardiance (diabetic) 10 mg, and lamotrigine (anticonvulsant) 150 mg in the morning. Review of a written statement by Licensed Practical Nurse (LPN) 2 dated 05/13/25 stated, “On 05/11/25, I was working on the 700 unit for AM [morning] shift. I was preparing to give [R8]’s medications, the aid was getting him dressed. I went into [another resident’s] room and came out. A patient wheeled up to the cart asked if I had something for him. I said yes I do. Let me take your BP [R8] and he gave me his arm to get is vitals. I asked him about how unique his name and how he looked like the actor. He said he got that before. He said he was really ready to get to breakfast. I said ok. I have your meds ready. I gave who I thought to be [R8] his meds. I said have a good day, see you later, enjoy breakfast [R8]. He proceeded to breakfast. I continued my med pass and about an hour later the aid wheeled who I knew to be [R8] back to the unit and asked if I could check him. He wasn’t himself, very sleepy. I rubbed his chest, called him [R8] 2x and the aid asked what did you call him. I said [R8]. [The aid] said that’s not [R8], that’s [R1]. I immediately opened my med drawer to see and make sure I didn’t give him [R8]’s med and I discovered I had. I took his vital signs and blood sugar, took him to the nurses’ station, kept talking to him, not calling him [R8], but [R1]. Called for [another nurse] to help me and she told me what unit the supervisor was on to call her too and she would be right over. I called the supervisor, explained what happened. She told me to contact the doctor, and she would send another registered nurse to help me and call the family too. [We] felt because of [R1] condition changes and vital signed calling 911 to send him to the hospital was best not to wait for the doctor to call back. I normally would not give patients meds that wheel up to me.” Review of hospital records revealed R1 was hospitalized from [DATE] to 05/13/25. Review of LPN2’s employee record revealed she had been suspended pending the investigation and resigned from her position. During an observation on 07/11/25 at 11:50 AM, R1’s room was located across the hall from R8’s room. During an interview on 07/11/25 at 11:50 AM, R1 introduced himself. When asked if he received the wrong medications a month or two ago, he at first replied, “No, I got some wrong medications at the hospital. ” Then he said, “I got 14 wrong medications and had to go to the hospital because I was unconscious for a while. I was there for a week. I’m okay now.” During an interview on 07/11/25 at 2:10 PM, the Director of Nursing (DON) stated, “Medication errors are taken very seriously, and the resident was hospitalized . Nurses are expected to follow the six rights of medication administration and verify the resident’s identity.”