STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310682	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUSSEX	W240 N6351 MAPLE AVE SUSSEX, WI 53089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 08/12/2024, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Brookdale Sussex, located at W240 N6351 Maple Avenue in Sussex, WI. One citation of noncompliance was issued. The complaint was substantiated. Census: 15	N 000		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 was transferred in a manner to meet Resident 1's personal care needs. Caregivers utilized a Hoyer (mechanical) lift incorrectly resulting in Resident 1's significant injury.	N 425		

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
	310682	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUSSEX	W240 N6351 MAPLE AVE SUSSEX, WI 53089

(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 425	Continued From page 1 On 12/03/2023, Caregiver C and Caregiver D attempted to transfer Resident 1 with a Hoyer lift from a recliner to a wheelchair in Resident 1's bedroom. The caregivers did not ensure the base or legs of the lift were correctly opened causing the Hoyer lift to tip over with Resident 1 in the lift and landing on Resident 1. As a result, Resident 1 was hospitalized with significant injury to his/her thoracic vertebrae requiring surgery. The findings included: On 07/15/2024, the department received a complaint alleging a resident was injured when caregivers did not correctly utilize a mechanical lift to transfer a resident. On 08/12/2024 at 10:15 A.M., Surveyor conducted an interview with Administrator A. Administrator A told Surveyor Resident 1 was injured and sent to the hospital following an incident on 12/03/2023 when 2 caregivers utilized a Hoyer lift incorrectly causing it to tip over while attempting to transfer Resident 1 from a recliner to Resident 1's wheelchair. Administrator A told Surveyor Resident 1 was hospitalized before being admitted to a skilled nursing facility and did not return to the provider's facility. Administrator A said this incident involving Resident 1 was an isolated incident. Administrator A told Surveyor there were 2 current residents, Resident 2 and Resident 3, that required caregiver assistance and the use of a mechanical lift with all transfers. On 08/12/2024, Surveyor reviewed Resident 1's record, as provided by Administrator A. Resident 1 was admitted to the facility on 01/14/2022 with diagnoses including cognitive communication deficit, osteoarthritis, a history of left fibula [leg bone] fracture, and presence of right artificial	N 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310682	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUSSEX	W240 N6351 MAPLE AVE SUSSEX, WI 53089

(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 425	Continued From page 2	N 425		

knee joint. Resident 1's diagnoses included reduced mobility, need for assistance with personal care, and a history of falls. Resident 1's individual service plan dated 06/19/2023 included, "[Resident 1] will be observed in the routine course of care for the risk of bleeding and bruising related to anticoagulant therapy." Resident 1's ISP documentation included Resident 1's height of 6 feet 2 inches. Resident 1's ISP included, "[Resident 1] requires assistance of two [2 caregivers] to transfer with sit to stand [mechanical lift]" and "[Resident 1] has a walker, but is not currently ambulating." Administrator A said Resident 1 was both tall and large in stature at the time of the incident on 12/03/2023. Administrator A told Surveyor the facility requested an order for a Hoyer lift from Resident 1's primary physician/practitioner on 01/31/2023. Administrator A said Resident 1's primary physician/practitioner conducted a visit with Resident 1 at the facility on 02/11/2023 before the facility received a written order for Resident 1's Hoyer lift on 02/24/2023. Administrator A told Surveyor s/he did not realize Former Health and Wellness Director [HWD] E had not updated Resident 1's ISP to reflect the new order for a Hoyer lift to be utilized instead of a sit to stand mechanical lift. Administrator A told Surveyor the caregivers were utilizing a Hoyer lift to transfer Resident 1 in the months leading up to and during the transfer on 12/03/2023.

On 08/12/2024 at approximately 10:30 A.M., Administrator A provided Surveyor with a copy of Resident 1's "Misconduct Incident Report" dated 12/11/2023 regarding an incident involving Resident 1 on 12/03/2023 at 11:00 A.M. Administrator A told Surveyor s/he prepared and submitted this report to the department's Office of Caregiver Quality on 12/11/2023 related to an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310682	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUSSEX	W240 N6351 MAPLE AVE SUSSEX, WI 53089

(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 425	Continued From page 3	N 425		

allegation of caregiver misconduct, as documented at the end of the report. The report included, "[Resident 1] was being transferred in [his/her] room from [his/her] recliner to [his/her] wheelchair using a Hoyer lift by staff members [Former Caregiver C] (operator) and [Caregiver D] (spotter). [Resident 1] was lifted in the air by [Former Caregiver C] with the Hoyer lift legs [base] closed resulting in an imbalance of the lift. As a result, the [Hoyer] lift fell over with [Resident 1] in it. [Resident 1] landed on [his/her] back and hit [his/her] head. No bleeding noted. [Caregiver D] was knocked to the floor from the force of [Resident 1] falling on top of [Caregiver D]. [Caregiver D] was able [to] get out from under [Resident 1] and get assistance from other staff. [Caregiver D] had staff member [Caregiver F] call 911 and instructed staff member [Caregiver G] to help in getting the lift off of [Resident 1]. [Caregiver G], [Caregiver D], and [Former Caregiver C] then lifted the Hoyer [lift] off of [Resident 1]. Care staff called 911 and [Resident 1] was transferred to ER [emergency room] by EMS [emergency medical services] personal (sic)." The documentation included, "At the time of the incident, [Resident 1] was scared and in pain. No visible injuries were present at the time of the incident." The documentation included, "After the incident occurred, an investigation immediately began. [Former Caregiver C] and [Caregiver D] were suspended pending the investigation. After concluding the investigation, [Former Caregiver C], the lift operator, was terminated. Additionally, [Caregiver D], the spotter, was given a final corrective action. Re-education for staff on mechanical lift transfers was provided by [Health and Wellness Director (HWD) B] on 12/06/2023."
The documentation included, "[Former Caregiver C] was operating the Hoyer lift and [Caregiver D]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310682	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUSSEX	W240 N6351 MAPLE AVE SUSSEX, WI 53089

(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 425	Continued From page 4	N 425		

was spotting [Resident 1]. [Resident 1] was lifted into the air, the lift was in the locked position, and then the Hoyer suddenly flipped over on its side. It was found that the Hoyer lift's legs were not opened at the time [Resident 1] was lifted into the air. [Resident 1] fell directly onto [his/her] back and hit [his/her] head. [Caregiver D] called for assistance. [Caregiver F] called 911. The Hoyer [lift] was lifted off [Resident 1] as [s/he] stated it was hard to breath. [Caregiver F] held [Resident 1's] neck in place until the EMS arrived. [Resident 1] never lost consciousness, there was no presence of blood, but [s/he] did get the wind knocked out of [him/her]. [Resident 1] was then transferred to the hospital via EMS."

Administrator A provided Surveyor with documentation of Resident 1's "physician/nurses notes." The documentation included, "[Resident 1] is admitted to [hospital]. [Resident 1] originally presented at ER at the [hospital's location] with mechanical fall from Hoyer lift at [his/her] facility. [Resident 1] reports [s/he] is wheelchair bound and was in Hoyer lift being moved when [s/he] fell to ground from height of 3-4 ft [feet]." The documentation included, "XR [x-ray] L [left] humerus [upper arm]: high riding left humeral head suggestive of full thickness rotator cuff [shoulder muscle group] tear."

The "Misconduct Incident Report" documentation included, "[Resident 1] has a 3 column fracture extending obliquely [at a slant[from anterior T [thoracic spine vertebrae] 7 through T7-T8 disk space and T8 vertebral body into T8-T9 posterior elements with disruption of the anterior longitudinal ligament at T7 but no significant spinal cord narrowing. [Resident 1] is having surgery on 12/08/2023 at [hospital]. Procedure will be a T4-T12 posterior fusion."

Administrator A told Surveyor Resident 1 was assessed at Resident 1's skilled nursing facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310682	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUSSEX	W240 N6351 MAPLE AVE SUSSEX, WI 53089

(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 425	Continued From page 5	N 425		

for readmittance to the facility. Administrator A told Surveyor Resident 1 was not appropriate for readmittance to the facility based on Resident 1's ongoing anticoagulant therapy and monitoring and Resident 1 was essentially bed-bound and limited to short periods of sitting up in Resident 1's wheelchair.

On 08/12/2024 at approximately 12:15 P.M., Surveyor reviewed Former Caregiver C's and Caregiver D's employee files, as provided by Administrator A, including documentation of completed training related to mechanical lifts provided by the facility. Administrator A told Surveyor Former Caregiver C inaccurately told EMS personnel s/he had not received training using the Hoyer lift and that s/he was using the Hoyer lift to transfer Resident 1 alone on 12/03/2023. Former Caregiver C was hired at the facility on 12/13/2021. Former Caregiver C's employee file included documentation Former Caregiver C completed hands-on training titled "Safe Resident Transfers" on "March 2022" and hands-on training including Hoyer lift transfers on 03/13/2023. Former Caregiver C's documentation included training completed "online" related to resident transfers on 12/18/2021, 10/09/2022, 10/13/2022, and 03/01/2023. Caregiver D was hired at the facility on 07/24/2022. Caregiver D's employee file included Caregiver D completed "online" training related to resident transfers on 07/29/2022, 08/15/2022, and 10/10/2022. Administrator A told Surveyor Caregiver D had not completed hands-on training related to resident transfers utilizing mechanical lifts prior to Resident 1's incident on 12/03/2023.

On 08/12/2024 at 12:38 P.M., HWD B told Surveyor following Resident 1's incident on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310682	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUSSEX	W240 N6351 MAPLE AVE SUSSEX, WI 53089

(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 425	Continued From page 6 12/03/2023 s/he now conducts hands-on training with all employees related to transfers utilizing mechanical lifts and observes each caregiver demonstrate a transfer utilizing each mechanical lift. Summary: the provider did not ensure Resident 1 was transferred in a manner to meet Resident 1's personal care needs. Caregivers utilized a Hoyer (mechanical) lift incorrectly resulting in Resident 1's significant injury.	N 425		