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 _____	07/08/2025

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 07/08/2025, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey at Brookdale Sussex, located at W240 N6351 Maple Avenue in Sussex, WI. One citation of noncompliance was issued. Census: 19	N 000		
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 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 the existence and/or use of a side rail on Resident 1's bed had been assessed prior to existence or use. The findings are: On 07/08/2025 at approximately 9:43 A.M., Surveyor observed Resident 1 in his/her bed with his/her eyes closed and Occupational Therapist F seated within Resident 1's room. Surveyor	N 381		

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

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N 381	Continued From page 1	N 381		

observed a half side rail in the up position located on the right side/open side of Resident 1's bed. The other side of Resident 1's bed was flush with full height wall. Surveyor observed a fall mat located under Resident 1's bed. Surveyor observed a walker located near Resident 1's bed. Occupational Therapist F told Surveyor s/he was visiting Resident 1 for a scheduled therapy appointment and had been notified by a caregiver Resident 1 had experienced an unwitnessed fall earlier on this morning. Occupational Therapist F told Surveyor Resident 1 was observed by a caregiver to be seated on the floor on Resident 1's bottom by his/her bed. Occupational Therapist F told Surveyor physical and occupational therapy services were recently started for Resident 1 related to recent falls experienced by Resident 1. Occupational Therapist F told Surveyor Resident 1 remained able to ambulate with the walker and physical therapy was working with Resident 1 related to strengthening.

On 07/08/2025 at approximately 11:45 A.M., Surveyor observed Resident 1 ambulating independently with the use of a walker in the dining room area of the facility.

On 07/08/2025 at approximately 2:00 P.M., Surveyor conducted an interview with Caregiver G and Caregiver H. Caregiver G told Surveyor the floor mat under Resident 1's bed "all of a sudden showed up" and was not used because Resident 1 was still ambulatory and it would be a trip hazard for Resident 1. Caregiver C told Surveyor s/he was not sure why or when the side rail was attached to Resident 1's bed. Caregiver H told Surveyor s/he thought the side rail had been attached to and in the up position on Resident 1's bed since Caregiver H started

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N 381	Continued From page 2	N 381		

working at the facility in August 2024.

On 07/08/2025, Surveyor reviewed Resident 1's record, as provided by Assistant Administrator B. Resident 1 was admitted to the facility on 07/08/2024 with diagnoses including dementia and bone disorders associated with Resident 1's feet.
Resident 1's record included the following documented assessments, an initial assessment on 07/02/2024, a 14 to 30 day assessment on 08/10/2024, and a "scheduled reassessment" on 02/20/2025. All 3 assessments included Resident 1 was a fall risk and did not include the existence/use of a side rail on Resident 1's bed nor the use of a fall mat.
Resident 1's most recent individual service plan (ISP), dated 02/20/2025, did not include the the existence/use of a side rail on Resident 1's bed nor the existence/use of a fall mat.

On 07/08/2025 at approximately 2:05 P.M., Licensed Practical Nurse (LPN) D told Surveyor s/he was not aware of whom or when the side rail was attached and placed in the up position on Resident 1's bed. LPN D told Surveyor s/he thought perhaps Resident 1's family may have attached the side rail and provided the fall mat under Resident 1's bed. LPN D said the side rail was not something provided by the facility. LPN D told Surveyor s/he reviewed Resident 1's 3 electronically documented assessments and Resident 1's hand-written record and found no evidence of an assessment for the use of a side rail on Resident 1's bed.

On 07/08/2025 at approximately 3:30 P.M., Surveyor conducted an exit interview with Administrator A, Assistant Administrator B, LPN C, and LPN D. LPN C told Surveyor s/he had just

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N 381	Continued From page 3 returned from medical leave on this day after approximately 1 month and was not aware of the use nor existence of a side rail on Resident 1's bed. Administrator A and LPN D told Surveyor they would be contacting Resident 1's family to inquire about the side rail and fall mat and conduct an assessment for both devices to determine their use or discontinuance.	N 381		