

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 310345	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/01/2023
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NAME OF PROVIDER OR SUPPLIER BROOKDALE BROOKFIELD CAPITOL DRIVE	STREET ADDRESS, CITY, STATE, ZIP CODE 15100 W CAPITOL DR BROOKFIELD, WI 53005
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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 000	<p>Initial Comments</p> <p>On 03/01/2023, Surveyor conducted a verification visit and complaint investigation at Brookdale Brookfield Capitol Drive, a CBRF in Brookfield.</p> <p>No deficiencies were identified. Statement of Deficiency (SOD) L5FU11, dated 09/14/2022, was corrected.</p> <p>The complaint was unsubstantiated.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 14</p>	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE