STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018374	A. BUILDING: _____ B. WING _____	C 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING SUN PRAIRIE	275 NORTH CITY DRIVE SUN PRAIRIE, WI 53590

(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 12/03/2025, the bureau of assisted living southern regional office conducted a complaint investigation at Talamore Senior Living a CBRF located in Sun Prairie, WI. As a result of this survey, 1 violation of DHS Chapter 83 was issued. Complaint was substantiated. Census: 26	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner. From 11/15/2025 to 11/17/2025, Resident 1 received the incorrect dose of Sertraline. Resident 1 was ordered Sertraline 200 mg but was instead administered 350 mg of Sertraline. From 09/09/2025 to 09/15/2025, Resident 2 did not receive 2 packets of Potassium Chloride 20MEQ as prescribed. From 06/25/2025 to 12/03/2025, Resident 4 was	N 352		

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
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N 352	Continued From page 1	N 352		

not administered his/her Flovent inhaler 220MCG as prescribed. Staff documented 255 administrations from the empty Flovent inhaler.

This is a repeat of statement of deficiency (SOD) OKJS11 dated 06/01/2023.

FINDINGS INCLUDE:

Facility provided care to the following client groups: irreversible dementia and Alzheimer's disease.

On 11/19/2025, the Department received a complaint regarding resident rights and program services.

On 12/03/2025, Surveyor arrived at facility for a complaint investigation.

OBSERVATION:

On 12/03/2025 at 10:00 AM, Surveyor conducted a medication cart audit with Nurse B. Caregiver C introduced himself/herself stated s/he was passing medications that morning. Caregiver C gave Nurse B keys to the medication cart. Surveyor opened the top drawer of the medication cart and reviewed the external/internal therapies stored inside. Surveyor picked-up Resident 4's Flovent Inhaler (fluticasone) 220mcg and found the counter on the back read "ooo" (Picture 2). Surveyor then reviewed the pharmacy label on the Flovent Inhaler (Picture 3). The inhaler was dispensed on 05/13/2025 with 132 puffs (doses). Nurse B verified Resident 4's Flovent Inhaler's fill date and quantity as of 05/13/2025. Nurse B asked Caregiver C to come back to the medication cart. Surveyor then asked Caregiver C if s/he administered any puffs from

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N 352	Continued From page 2 Resident's Flovent inhaler that morning. Caregiver C stated s/he administered the last 2 puffs of the Flovent Inhaler that morning. Caregiver C stated s/he thought there was another Flovent Inhaler stored in the medication room for Resident 4. Caregiver C left the medication cart, entered the medication room, and reported to Surveyor upon return that the only Flovent Inhaler for Resident 4 was the one in Surveyor's hand. Surveyor notified Caregiver C that it appeared Resident 4's Flovent inhaler hadn't been refilled since 05/13/2025. Caregiver C maintained that s/he dispensed that last 2 puffs from the Flovent Inhaler that morning. Surveyor then continued medication cart audit. Surveyor picked up a Resident 2's pharmacy labeled bag of Potassium Chloride Powder 20MEQ and observed 2 packets inside (Picture 1). Surveyor reviewed the pharmacy label in the bag, "7 PACK ...09/06/25 ... (09/07-09/13/2025) TAKE 1 PACKET ONCE DAILY FOR 7 DAYS FOR HYPOKALEMIA." Surveyor showed Nurse B Resident 2's Potassium Chloride packets with pharmacy label. Nurse B acknowledged Resident 2's Potassium Chloride was scheduled to end on 9/13/2025 and stated s/he would follow-up on why they weren't administered. Surveyor opened the second drawer of the medication cart and observed a tube Resident 3' Ammonium Lactate Cream placed between resident blister packs of PO (by mouth) medications. Resident 3's Ammonium Lactate Cream did not have a barrier (bag) around it. Nurse B acknowledged Resident 3's external cream cannot be stored in contact with resident internal medication packaging (Picture 4). RECORD REVIEW: EXAMPLE 1: Resident 1	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018374	A. BUILDING: _____ B. WING _____	C 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING SUN PRAIRIE	275 NORTH CITY DRIVE SUN PRAIRIE, WI 53590

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N 352	Continued From page 3 On 12/03/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 06/13/2025. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: frontotemporal dementia and depression. On 12/03/2025, Surveyor reviewed Resident 1's observation notes. On 11/19/2025 at 3:32 PM, Assistant Director Of Nursing (ADON) H documented the following, "DETAILS: Recent dose increase from 150 mg to 200 mg daily. 200 mg dose card arrived with pharmacy delivery on evening of 11/14/25 and was put into medication cart. on (sic.) 11/15, 11/16, and 11/17 both doses of medication was (sic.) administered to patient for a total of 350 mg each day for three days. on (sic.) 11/18 the morning med passer realized both cards were in the cart and reported the error. On 11/18 only 200 mg was administered to patient ...". EXAMPLE 2: Resident 2 On 12/03/2025, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to the facility on 07/25/2024. Resident 2 was diagnosed with but not limited to: Parkinson's disease, neurocognitive disorder with Lewy bodies, disorder of the autonomic nervous system, supraventricular tachycardia and restless legs syndrome. On 12/03/2025, Surveyor reviewed Resident 2's September 2025 medication administration record (MAR). Surveyor reviewed the following order, "POT CHLORIDE POW 20MEQ (09/07-09/13/2025) TAKE 1 PACKET ONCE DAILY FOR 7 DAYS FOR HYPOKALEMIA."	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 4 Surveyor reviewed 7 doses documented as administered from 09/09/2025 to 09/15/2025. EXAMPLE 3: Resident 4 On 12/03/2025, Surveyor reviewed Resident 4's facility record. Resident 4 was admitted to the facility on 08/25/2022. Resident 4 had an activated power of attorney. Resident 4 was diagnosed with but not limited to: unspecified dementia, cognitive communication deficit, unspecified asthma and history of traumatic brain injury. On 12/03/2025, Surveyor reviewed Resident 4's individualized service plan (ISP) signed on 08/26/2025. Surveyor reviewed Resident 4 was ordered continuous oxygen therapy via nasal cannula to be set at 2LPM (liters per minute) and was to have his/her oxygen saturation measured 3 times daily. Staff instructed to notify the nurse if Resident 4's oxygen saturation was below 90%. On 12/03/2025, Surveyor reviewed Resident 4's May 2025 MAR. Surveyor reviewed the following order, "FLUTICA HFA AER 220MCG (FLOVENT HFA) INHALE 2 PUFFS BY MOUTH DAILY FOR ASTHMA ...Effective: 05/13/2025 ...". From 05/13/2025 to 05/31/2025, Resident 4 was documented as being administered the Flovent inhaler 36 times (72 puffs) and refused 1 time. On 12/03/2025, Surveyor reviewed Resident 4's June 2025 MAR. Surveyor reviewed the following order, "FLUTICA HFA AER 220MCG (FLOVENT HFA) INHALE 2 PUFFS BY MOUTH DAILY FOR ASTHMA ...Effective: 05/13/2025 ...". From 06/01/2025 to 06/30/2025, Resident 4 was documented as being administered the Flovent inhaler 60 times (120 Puffs).	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 5 On 12/03/2025, Surveyor reviewed Resident 4's July 2025 MAR. Surveyor reviewed the following order, "FLUTICA HFA AER 220MCG (FLOVENT HFA) INHALE 2 PUFFS BY MOUTH DAILY FOR ASTHMA ...Effective: 05/13/2025 ...". From 07/01/2025 to 07/31/2025, Resident 4 was documented as being administered the Flovent inhaler 54 times (108 puffs) and refused 4 times. On 12/03/2025, Surveyor reviewed Resident 4's August 2025 MAR. Surveyor reviewed the following order, "FLUTICA HFA AER 220MCG (FLOVENT HFA) INHALE 2 PUFFS BY MOUTH DAILY FOR ASTHMA ...Effective: 05/13/2025 ...". From 08/01/2025 to 08/05/2025, Resident 4 was documented as "out of facility." From 08/06/2025 to 08/31/2025, Resident 4 was documented as being administered the Flovent inhaler 45 times (90 puffs) and refused 4 times. On 08/21/2025 at 7:00 AM, Caregiver 1 documented the inhaler was not in the medication cart and pharmacy needed to be notified. On 12/03/2025, Surveyor reviewed Resident 4's September 2025 MAR. Surveyor reviewed the following order, "FLUTICA HFA AER 220MCG (FLOVENT HFA) INHALE 2 PUFFS BY MOUTH DAILY FOR ASTHMA ...Effective: 05/13/2025 ...". From 09/01/2025 to 09/12/2025, Resident 4 was documented as being administered the Flovent inhaler 19 times (38 puffs) and refused 6 times. On 09/09/2025 at 3:00 PM, Caregiver J documented the inhaler was not in the medication cart and pharmacy needed to be notified. From 09/13/2025 to 09/25/2025, Resident 4 was documented as being hospitalized. From 09/26/2025 to 09/30/2025, Resident 4 was documented as being administered the inhaler 9 times (18 puffs) and refused once.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018374	A. BUILDING: _____ B. WING _____	C 12/03/2025

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N 352	Continued From page 6 On 12/03/2025, Surveyor reviewed Resident 4's October 2025 MAR. Surveyor reviewed the following order, "FLUTICA HFA AER 220MCG (FLOVENT HFA) INHALE 2 PUFFS BY MOUTH DAILY FOR ASTHMA ...Effective: 05/13/2025 ...". From 10/01/2025 to 10/31/2025, Resident 4 was documented as having been administered the Flovent inhaler 58 times (116 puffs) and refused 4 times. On 12/03/2025, Surveyor reviewed Resident 4's November 2025 MAR. Surveyor reviewed the following order, "FLUTICA HFA AER 220MCG (FLOVENT HFA) INHALE 2 PUFFS BY MOUTH DAILY FOR ASTHMA ...Effective: 05/13/2025 ...". From 11/01/2025 to 11/30/2025, as being administered the Flovent inhaler 56 times (112 puffs) and refused 4 times. On 12/03/2025, Surveyor reviewed Resident 4's December 2025 MAR. Surveyor reviewed the following order, "FLUTICA HFA AER 220MCG (FLOVENT HFA) INHALE 2 PUFFS BY MOUTH DAILY FOR ASTHMA ...Effective: 05/13/2025 ...". From 12/01/2025 to 12/03/2025, as being administered the Flovent inhaler 4 times (8 puffs) and refused once. INTERVIEW: On 12/03/2025 at 11:11AM, Surveyor showed Nurse B Resident 2's potassium chloride packets had been documented as administered for 7 days in September 2025. Nurse B acknowledged there were 2 packets left over in the medication cart. Nurse B stated s/he would continue to investigate why the 2 packets of potassium chloride weren't administered to Resident 2.	N 352		

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	0018374	A. BUILDING: _____ B. WING _____	C 12/03/2025

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N 352	Continued From page 7 On 12/03/2025 at 11:45AM, Surveyor called [Name of Pharmacy] and interviewed Pharmacist K. Pharmacist K stated his/her pharmacy dispensed Resident 4's medications and looked up Resident 4's clinical chart. Pharmacist K stated the last time Resident 4's Flovent inhaler was dispensed was on 05/13/2025. Pharmacist K stated the Flovent inhaler contains 120 metered doses (puffs) which would equal a 30-day supply for Resident 4's prescribed order of 2 puffs administered twice daily. On 12/03/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator A, Nurse B, Regional Nurse E, Regional Director G and Regional Director F. Administrator A, Nurse B, Regional Nurse E, Regional Director G and Regional Director F acknowledged Resident 1 was administered incorrect doses of Sertraline from 11/15/2025 to 11/17/2025. Administrator A, Nurse B, Regional Nurse E, Regional Director G and Regional Director F acknowledged Resident 2 wasn't administered 2 of his/her prescribed packets of potassium chloride as prescribed. Administrator A, Nurse B, Regional Nurse E, Regional Director G and Regional Director F acknowledged Resident 4's Flovent inhaler had been documented as administered from 06/25/2025 to 12/03/2025 many days by facility staff, and had the Flovent inhaler been documented accurately from 05/13/2025 to 06/24/2025 it would have been emptied by 06/25/2025. Nurse B explained s/he had recently started employment with facility and would be implementing consistent medication cart audits as soon as possible. Nurse B acknowledged staff would need to be re-trained on inhaler administration and re-ordering schedule. Regional Nurse E explained facilities electronic health record (EHR) does allow staff to re-order	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 8 inhaler(s) from pharmacy and staff would be educated on monitoring the metered dose counter.	N 352		