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 _____	R 01/31/2025

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 000	Initial Comments On 01/28/2025, with information obtained through 01/31/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Talamore Senior Living Sun Prairie, a community-based residential facility (CBRF) located in Sun Prairie, WI. As a result of the survey, 5 deficiencies were identified. Four deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) FF1V11, dated 08/16/2024. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 21	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a written report was sent to the Department within 3 working days after Resident 3 experienced a fall requiring him/her to have head staples placed in the emergency department, or after Resident 6 experienced a fall that required him/her to have his/her finger dislocation set in the emergency	N 165		

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 165	Continued From page 1	N 165		

department.

Findings include:

Example 1 - Resident 3

On 01/28/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 10/05/2022 with diagnoses including vascular dementia, depression, and osteoporosis. Surveyor reviewed an after visit summary for an incident when Resident 3 was admitted to the emergency department on 12/30/2024. The summary documented that Resident 3 had a "fall with head injury" and that the cut on the back of Resident 3's head was closed with staples.

On 01/30/2025, Surveyor reviewed Department records for the provider. There was a self-report submitted on 01/02/2025 which detailed 1 fall Resident 3 experienced on that day at 4:45 ("a.m." and "p.m." boxes were both checked) in which Resident 3 was found by staff on his/her back next to his/her dresser and table and experienced a head strike with bleeding as well as complaints of left hip pain. The note detailed that Resident 3 returned from the emergency department that day with sutures on his/her head laceration and a diagnosis of a left closed hip fracture. There was no information regarding a separate fall incident resulting in head staple placement that occurred after a separate fall on 12/30/2024.

On 01/31/2025, at approximately 10:54 a.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported being unsure if a self-report was sent regarding the 12/30/2024 fall with resulting head staple placement and reported they would have to look

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 _____	R 01/31/2025

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N 165	Continued From page 2 into it. Nothing further was received. Example 2 - Resident 6 On 01/28/2025, at approximately 10:10 a.m., Surveyor interviewed Caregiver H regarding residents' needs. Caregiver H reported that after one recent fall at the end of December, Resident 6 had dislocated his/her finger and had a head contusion which required hospitalization. Caregiver H asked Surveyor if that was an incident that was supposed to have been reported to the state, because s/he recalled hearing the past person in charge saying they did not have to report it. On 01/28/2025, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 12/20/2023 with diagnoses including major neurocognitive disorder, vascular dementia, orthostatic hypotension, and repeated falls. Surveyor reviewed Resident 6's progress notes, which included the following: - 12/23/2024: "Staff placed call to triage nurse at 7:05 pm to report the resident has fallen and [s/he] will be sent to [local hospital]. Staff reports the fall was unwitnessed, but the resident was injured. Staff reports the resident disclosed that [s/he] was walked into the bathroom with [his/her] walker, tried taking [his/her] pants down and fell. Staff reports a skin break to the left side of the resident's head, skin tear located on the left arm and [his/her] left finger could be potentially broken ..." An entry on 12/24/2024 at 12:49 p.m. documented that resident remained hospitalized. An entry on 12/28/2024 documented that a new order was received for wound care to be initiated to Resident 6's left arm.	N 165		

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 _____	R 01/31/2025

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TALAMORE SENIOR LIVING SUN PRAIRIE	275 NORTH CITY DRIVE SUN PRAIRIE, WI 53590

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N 165	Continued From page 3 - 12/28/2024: "Per [hospice agency] ...New order: Wound care left arm skin tear change every 5 days and [as needed] for drainage ..." In reviewing Resident 6's record, Surveyor observed that Resident 6 was documented as being out of the facility from 12/22/2024 through 12/26/2024. Surveyor reviewed a hospice nursing note located within Resident 6's record, dated 01/14/2025, which documented: " ...patient has wound on [his/her] left forearm that has resolved and wound and left forehead is scabbed over, skin intact at this time ...[S/he] has some discomfort in [his/her] left ring finger, this was dislocated during [his/her] fall on December 22.Slight [sic] amount of bruising and knuckle appears swollen." Surveyor observed that this seemed to corroborate the 12/23/2024 progress note above detailing the injuries Resident 6 sustained after a fall, as well as Caregiver H's report. There were no other notes in Resident 6's record, including available medical records, that had information regarding Resident 6's finger dislocation or left forearm wound. At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported being unsure if a self-report had been submitted for the above incident. Surveyor requested any additional information the provider had regarding this incident as well as any additional evidence of a self-report having been submitted. No evidence of a self-report being submitted was received.	N 165		

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N 165	Continued From page 4 On 01/30/2025, Surveyor reviewed Department records for the provider. There was no evidence of a self-report having been sent for the above incident. On 01/31/2025, at approximately 10:54 a.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Director of Nursing K reported that this occurred prior to him/her working with the provider and s/he learned that the previous nurse did not submit a self-report regarding the above incident. Director of Nursing K reported s/he was unaware of the left arm wound care information that Surveyor had reviewed from Resident 6's notes, but that Resident 6 had his/her finger dislocation addressed while admitted to the emergency department.	N 165		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by:	N 230		

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 _____	R 01/31/2025

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 230	Continued From page 5 Based on record review and interview, the provider did not ensure that 3 of 3 employees reviewed obtained orientation training that included all the required topics before performing any job duties. Caregivers, G, H, and I did not have training in recognizing and responding to resident changes of condition. This is a repeat deficiency. See Statement of Deficiency (SOD) FF1V11, dated 08/16/2024. Findings include: On 01/28/2025, Surveyor conducted a review of 3 employees to verify compliance with orientation training requirements. Surveyor requested training records from Business Office Manager J for Caregivers G, H, and I. The training record for Caregiver G, hired 10/14/2024, did not contain evidence of training in recognizing and responding to resident changes of condition. The training record for Caregiver H, hired 09/25/2024, did not contain evidence of training in recognizing and responding to resident changes of condition. The training record for Caregiver I, hired 10/14/2024, did not contain evidence of training in recognizing and responding to resident changes of condition. At approximately 1:30 p.m., Surveyor interviewed Business Office Manager J. Business Office Manager J reported s/he wasn't sure if maybe change of condition training was covered as part	N 230		

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 _____	R 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 230	Continued From page 6 of another topic during the onboarding of caregiving staff, if it was trained in as part of its own training topic, or if s/he had any evidence of training provided in recognizing and responding to resident changes of condition. At approximately 2:00 p.m., Business Office Manager J confirmed s/he had no evidence that Caregivers G, H, and I completed training in recognizing and responding to resident changes of condition. Business Office Manager J reported that the provider had been working to ensure staff compliance with training and that the provider would be changing in the near future how onboarding training would be conducted.	N 230		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 3 staff reviewed completed their continuing education in all the required topics.	N 277		

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 _____	R 01/31/2025

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 277	Continued From page 7 Caregivers M and N did not complete 2024 continuing education in standard precautions (outside of handwashing), resident rights, and fire safety and emergency procedures to include first aid. This is a repeat deficiency. See Statement of Deficiency (SOD) FF1V11, dated 08/16/2024. Findings include: On 01/28/2025, Surveyor conducted a review of 3 employees to verify compliance with continuing education requirements. Surveyor requested all 2024 training records for Caregivers M and N from Business Office Manager J. Example 1 - Caregiver M The 2024 training record for Caregiver M, hired 08/10/2022, did not contain evidence of training in standard precautions, resident rights, or fire safety and emergency procedures to include first aid. At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Business Office Manager J reported that training was also provided during monthly meetings. Surveyor then requested all monthly meeting documentation for 2024, due 01/29/2025 at 12:00 p.m. On 01/30/2025, Surveyor reviewed the training records provided. There was evidence of handwashing training completed during October's meeting, which Caregiver M attended, but no evidence of any other standard precaution-related training. There was no evidence from the records	N 277		

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 _____	R 01/31/2025

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 277	Continued From page 8	N 277		

provided of training completed by Caregiver M in 2024 for resident rights or fire safety and emergency procedures to include first aid.

On 01/31/2025, at approximately 10:54 a.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported understanding of Surveyor's concern that there was no evidence Caregiver M completed training in 2024 in standard precautions (outside of handwashing), resident rights, or fire safety and emergency procedures to include first aid. Business Office Manager J reported that the provider was still in the process of updating training for staff.

Example 2 - Caregiver N

The 2024 training record for Caregiver N, hired 12/08/2023, did not contain evidence of training in standard precautions, resident rights, or fire safety and emergency procedures to include first aid.

At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Business Office Manager J reported that training was also provided during monthly meetings. Surveyor requested all monthly meeting documentation for 2024, due 01/29/2025 at 12:00 p.m.

On 01/30/2025, Surveyor reviewed the training records provided. There was evidence of handwashing training completed during October's meeting, which Caregiver N attended, but no evidence of any other standard precaution-related training. There was no evidence from the records provided of training completed by Caregiver N in 2024 in resident rights or fire safety and

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 _____	R 01/31/2025

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 277	Continued From page 9 emergency procedures to include first aid. On 01/31/2025, at approximately 10:54 a.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported understanding of Surveyor's concern that there was no evidence Caregiver N completed training in 2024 regarding standard precautions (outside of handwashing), resident rights, or fire safety and emergency procedures to include first aid. Business Office Manager J reported that the provider was still in the process of updating training for staff.	N 277		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plans (ISPs) for 4 of 4 residents reviewed were updated to reflect changes in the residents' needs, abilities, and physical or mental condition.	N 389		

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 _____	R 01/31/2025

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 389	Continued From page 10	N 389		

Resident 2's ISP was not updated to include the extent of his/her aggressive behaviors or reflect accuracy of his/her behavior monitoring plan and log.

Resident 3's ISP was not updated to reflect his/her fall-related needs and updated ambulatory status. Resident 3 experienced 5 falls from 10/08/2024 - 01/28/2025, one of which resulted in a head laceration that required staples to close and another of which resulted in a left hip fracture, after which s/he primarily used a wheelchair (instead of his/her walker) for ambulation.

Resident 5's ISP was not updated to reflect his/her bedrail use and updated special diet.

Resident 6's ISP was not updated to reflect his/her fall risk and fall-related needs related to supervision recommendations made by his/her hospice team. Resident 6 experienced 4 falls from 11/13/2024 - 01/28/2025, one of which resulted in a left arm skin tear as well as a left ring finger dislocation.

This is a repeat deficiency. See Statement of Deficiency (SOD) FF1V11, dated 08/16/2024.

Findings include:

Example 1 - Resident 2's behaviors

On 01/28/2025, at approximately 10:10 a.m., Surveyor interviewed Caregiver H regarding residents' needs. Caregiver H reported that Resident 2 was known to have behaviors, which included being easily aggravated and getting aggressive. Caregiver H reported that it wasn't

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 _____	R 01/31/2025

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 389	Continued From page 11	N 389		

clear what his/her triggers were but s/he thought maybe it was due to his/her difficulties communicating with others. Caregiver H reported that Resident 2 had gotten in multiple physical altercations with other residents and attacked a family member of Resident 6 in that resident's room sometime around the end of December. Caregiver H that Resident 6's family member complained of having a bruised rib after the incident. Caregiver H reported that generally staff tried to increase their supervision of Resident 2 and attempted to redirect him/her to mitigate his/her behaviors. Caregiver H reported that this was difficult, however, because Resident 2 wasn't always easily redirectable. Caregiver H reported that staff also at times called Resident 2's family who would then attempt to verbally intervene and guide Resident 2. Caregiver H reported that Resident 2's physical outbursts happened a little less than weekly and included hitting, kicking, and cursing at either staff and/or others.

On 01/28/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 10/25/2021 with diagnoses including Alzheimer's dementia, depression, and anxiety disorder. Resident 2 was documented as having an activated power of attorney (POA) for healthcare. In reviewing Resident 2's progress notes, Surveyor observed the following in relation to his/her aggressive behaviors:

- 11/01/2024: Incident entry for "Resident to staff altercation" which documented, "Resident went to another resident's room, The [sic] staff found [him/her] and tried to get [him/her] out, but couldn't, called another staff member for help, snack was offered did not work and [s/he] slapped the staff on the [his/her] face on the right eye while talking to [him/her]."

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 _____	R 01/31/2025

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 389	Continued From page 12 - 11/23/2024: "5:35pm- call received from staff stating that resident is having increased anxiety/agitation, is being physically abusive toward staff and other resident. Resident slapped another resident...in the back and threw a cup of water at [him/her], staff were able to intervene to separate residents, resident is unable to be redirected after multiple attempts by staff..." - 11/29/2024: "Resident had a resident to resident altercation with [other resident] in kitchen area near sink and snack cupboard. Both residents were throwing punches at one another and [other resident] punched [Resident 2] in the mouth..." Another entry that day documented, "this on call [registered nurse] was contacted at 18:36 regarding resident to resident altercations. per care staff saw resident in the kitchen by the sink and noted to be exchanging hits by punching with another resident. Per care staff was able to redirect resident away from one another. Per care staff resident continues to be agitated. Per care staff unsure what stated [sic] disagreement. Resident noted to have blood coming from mouth and noted a tooth was knocked out. Per care staff whole toot [sic] was found on the ground." - 12/03/2024: "Change of condition assessment completed today and behavior management plan was updated..." - 12/17/2024: "Incident entry for "Alleged abuse" which documented, "...when i [sic] walked in i observed [Resident 2] sitting in chair in [Resident 6]'s kitchen area...family member stated [s/he] was hit in the rib area..." Another entry that day documented, "Direct care staff contacted writer to report incident, report resident went into another resident apartment, when family of resident	N 389		

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 _____	R 01/31/2025

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 389	Continued From page 13	N 389		

attempted to remove resident [s/he] pushed family member, staff then able to redirect out of apartment..."

Surveyor reviewed the 2 most recent individual service plans (ISPs) for Resident 2, the first dated 10/18/2024 and the current one dated 01/02/2025. In the ISP dated 10/18/2024, the following was documented regarding his/her aggressive behaviors and behavioral needs:

- "Document number of behaviors per shift.. Follow responsive behavior plan.. The community to provide assistance to monitor reactive behaviors in a supportive environment."

In the ISP dated 01/02/2025, the following was documented regarding his/her aggressive behaviors and behavioral needs:

- Service type: "Behavior: More than 5x/week," which documented, "DOCUMENT NUMBER OF BEHAVIORS THROUGHOUT THE SHIFT, REPORT CONCERNS TO [power of attorney (POA)].. Community to provide behavior monitoring."

- Service type: "Behavior: Plan Eval," which documented, "Evaluate the behavior management plan to assure that the plan is meeting resident's needs. Update Service Plan and interventions as needed, notify POA of changes."

- Service type: "Behavior: Management Plan" which documented the same information as Resident 2's 10/18/2024 ISP (documented above).

Surveyor did not observe in Resident 2's current

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 _____	R 01/31/2025

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 389	Continued From page 14 ISP information regarding Resident 2's specific behaviors or documented interventions as mentioned in the 01/02/2025 ISP. At approximately 2:00 p.m., Surveyor requested Resident 2's behavior management plan (as referenced from his/her ISP as well as referenced in his/her 12/03/2024 observation note entry) from Business Office Manager J. At approximately 2:20 p.m., Surveyor interviewed Business Office Manager J. Business Office Manager J reported that there really wasn't a specific behavior management plan but that the "plan" referenced a series of interventions staff were expected to utilize prior to administering Resident 2 his/her as needed (PRN) psychotropic medication. Business Office Manager J then provided Surveyor the "plan" which was a page of Resident 2's MAR which documenting his/her PRN lorazepam administration. The prescription order was to take 1 tablet every 4 hours as needed "for agitation and anxiety *hospice patient* anxiety only: must attempt 3 interventions first, if not effective call...for permission to give." The interventions listed were "1-Talking with resident, 2-Quiet environment, 3-Toileting/check and change." Business Office Manager J also reported that there was not a separate behavior log where staff documented the number of behaviors per shift and that this was tracked through the same MAR entry when Resident 2 was administered his/her PRN lorazepam. In then reviewing the MARs for Resident 2 from 11/01/2024 - 01/28/2025, Surveyor observed 2 administrations of PRN lorazepam - one tablet on 11/17/2024 at 2:51 p.m. for "anxiety" (no correlating behaviors documented in the MAR or progress notes), and one tablet on 11/23/2024 at 5:45 p.m. for "anxiousness, combati[veness]"	N 389		

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 _____	R 01/31/2025

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 389	Continued From page 15	N 389		

(seeming to correlate with the resident-to-resident altercation from his/her progress notes on the same day). There were otherwise no entries showing behavior tracking each shift as documented in his/her ISP.

At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported understanding of Surveyor's concern that the extent of Resident 2's aggressive behaviors, including physical aggression towards staff and other residents, was not documented in his/her ISP. Both also reported understanding of Surveyor's concern that Resident 2's ISP did not reflect that his/her behavior monitoring log, which the ISP called for tracking of during each shift, only tracked Resident 2's behaviors in relation to his/her PRN lorazepam administration in the MAR and not behaviors that occurred each shift.

Example 2 - Resident 3's falls and ambulatory status

On 01/28/2025, at approximately 10:10 a.m., Surveyor interviewed Caregiver H regarding residents' needs. Caregiver H reported that Resident 3 was known to have frequent falls. Caregiver H reported that Resident 3 demonstrated high anxiety behaviors which resulted in difficulties sitting still and caused him/her to frequently try to transfer him/herself. Caregiver H reported that when Resident 3 was ambulatory, s/he was supposed to be walking with a walker but was often walking without it. Caregiver H reported that for approximately the past month, Resident 3 had been wheelchair-bound for ambulation due to a hip fracture s/he experienced after a fall. Caregiver H reported that Resident 3 still would try to get out

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 _____	R 01/31/2025

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 389	Continued From page 16	N 389		

of his/her wheelchair by him/herself. Caregiver H reported that Resident 3 required a lot of staff individualized attention and cuing to avoid self-transferring. Caregiver H reported that Resident 3 was on 2-hour safety checks which was the same as every other resident but thought maybe s/he was on 1-hour checks during the nighttime hours. Caregiver H reported that s/he personally had been trying to maintain increased supervision of Resident 3 by having him/her out in the common area during the day but that this wasn't something s/he was instructed to do and s/he wasn't sure if other staff were doing this when s/he wasn't working.

On 01/28/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 10/05/2022 with diagnoses including vascular dementia, depression, and osteoporosis. Resident 3 was documented as having an activated POA for healthcare. In reviewing Resident 3's progress notes, Surveyor observed the following in relation to 5 falls s/he experienced:

- 10/08/2024: "Direct care staff contacted writer to report unwitnessed fall occurred at 10:50pm Resident [family member] contacted staff to report saw resident sitting on floor in middle of room. Denies pain ...no apparent injuries ..."

- An entry on 10/16/2024 appeared to copy/paste an e-mail from someone who identified themselves as a family member of Resident 3. The e-mail documented, "[Resident 3] has lost the ability to summon help with [his/her] pendant. Staff reminds [him/her] to use it, my [family member] reminds [him/her] to use it, but [s/he] doesn't remember what it's for. Recently [s/he] fell in [his/her] room at 10:15 p.m. Luckily not long

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 _____	R 01/31/2025

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 389	Continued From page 17 afterward my [family member] checked [his/her] camera and saw [him/her] on the floor. I called Memory Care staff who then came and helped [him/her]. [Resident 3] did not use [his/her] pendant to call for help ..." - Incident entry on 11/06/2024 which documented an unwitnessed fall that occurred on 11/05/2024 at 10:40 p.m. The entry documented, " ...[Family member] called around 10:40pm and said resident has been in floor for 30 mins ..." - Entry on 12/06/2024 documented that Resident 3's family began implementing a fall alert pendant, which "alerts the family of a fall, and they [sic] family notifies facility." - 12/30/2024: "Direct care staff contacted writer to report unwitnessed fall 08:45pm. Resident found lying on the floor in common area ...reports hitting head, open area right side head, bleeding ..." The note also documented that Resident 3 was transferred to the hospital. - 01/02/2025: "Call received from Caregiver at 4:50 AM to report unwitnessed fall of resident. Upon entry to room, resident was found lying on back next to dresser and table ...Staff report large amount of blood from back of head. Residents [sic] also reports significant back pain. Staff report calling [emergency medical services (EMS)] for assessment ...EMS reports resident has new laceration to back of head ...Currently, laceration being dressed. Also reports resident was seated to sitting position and is experiencing left hip pain." The note also documented that Resident 3 was transferred to the hospital. An entry later that day, at 11:06 a.m., documented, "[Resident 3] has a hip fracture."	N 389		

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 _____	R 01/31/2025

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 389	Continued From page 18	N 389		

- Incident entry on 01/15/2025 which documented an unwitnessed fall that occurred that day at 9:00 a.m. The entry documented, "Res was sitting on [his/her] butt in front of [his/her] wheelchair ...Two staff members assisted res off of the floor and set [him/her] back in [his/her] wheelchair ..."

Within Resident 3's record, Surveyor reviewed after visit summaries for 3 of Resident 3's emergency department admissions that occurred in relation to 3 separate falls s/he experienced, all corroborating progress note entries above. The summaries included the following:

- 11/06/2024: Emergency department admission for a fall
- 12/30/2024: Emergency department admission for "fall with head injury" which documented that the cut on the back of Resident 3's head was closed with staples
- 01/02/2025: Emergency department admission for a fall which resulted in "left-sided hip fracture" which was recommended to be treated nonoperatively.

Surveyor reviewed Resident 3's current ISP, dated 10/18/2024. Surveyor observed that this was reviewed after 1 of his/her falls but prior to the remaining 4 that were reviewed. Surveyor observed the following:

- "RETURN WALKER TO BEDSIDE DURING SAFETY CHECKS. [Resident 3] OFTEN LEAVES [HIS/HER] WALKER IN THE BATHROOM EACH TIME [S/HE] USES IT." A separate heading labeled "behavior" also documented Resident 3's walker use with the note, "please ensure [s/he] has [his/her] walker when ambulatory." A separate heading for Resident 3's ambulation needs documented that Resident 3 ambulated

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 _____	R 01/31/2025

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 389	Continued From page 19	N 389		

with "Standby assist with 4 wheeled walker and gaitbelt."

- Safety checks were documented as occurring 12x/day (equating to approximately every 2 hours, as reported by Caregiver H).

With Resident 3's ISP having last been reviewed on 10/18/2024, Surveyor observed no information about his/her fall risk or new fall risk mitigation interventions after Resident 3's most recent 4 falls (2 of which resulted injuries), as well as no updated information regarding his/her primary use of a wheelchair for ambulation since his/her 01/02/2025 fall.

At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported understanding Surveyor's concern that updates regarding Resident 3's ambulatory status and needs were not made to his/her ISP. Both reported understanding Surveyor's concern that there was not information about Resident 3's fall risk and fall risk mitigation interventions documented in his/her ISP and that it wasn't clear if the supervision intervention reported by Caregiver H was an intervention that was being implemented by all staff or just by Caregiver H since there were no defined documented parameters with it.

Example 3 - Resident 5's bedrails and special diet

On 01/28/2025, at approximately 9:57 a.m., Surveyor toured the environment and observed Resident 5's room. Resident 5's bed had bilateral upper quarter bed rails, both in the "up" position.

At approximately 10:10 a.m., Surveyor

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 _____	R 01/31/2025

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 389	Continued From page 20	N 389		

interviewed Caregiver H. Caregiver H reported that Resident 5's bedrails were typically in the "up" position, including through the night when Resident 5 was in bed.

On 01/28/2025, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 10/28/2021 with diagnoses including cerebrovascular disease, polyneuropathy, and unspecified dementia. Resident 5 was documented as having an activated POA for healthcare. In reviewing Resident 5's progress notes, Surveyor observed the following in relation to his/her choking risk/occurrences:

- 11/09/2024: "Choking on chips may need a diet change & thicken liquids."

- 01/07/2025: "The writer was called into the dining room and found that the resident was choking. Heimlich maneuvered [sic] performed to remove the stuck food. The resident vomited ..." An entry after this documented, "New order: Nectar thick liquids with regular diet."

Surveyor reviewed a medication list for Resident 5 which also included medical provider orders. One of the orders documented, "Diet: Nectar thick liquids with regular diet."

Surveyor reviewed Resident 5's current ISP, dated 01/08/2025. The ISP documented that Resident 5 was to receive nectar-thickened liquids only but documented no other specialty diet directives. There was no information regarding Resident 5's bed rail use in his/her ISP.

In reviewing Resident 5's hospice notes located within his/her record, Surveyor observed a note from his/her hospice nurse on 01/13/2025 which

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 _____	R 01/31/2025

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 389	Continued From page 21	N 389		

documented concerns with Resident 5's choking risk: "1615 - [telephone call] to [activated POA for healthcare] to discuss puree/soften diet. Writer suggested facility continue to track coughing episodes for the week. Will place call to provider to inform him/her of these episodes and determine when [s/he] would recommend starting a pureed diet. Factors to consider: patient has recently overcome respiratory symptoms. There was a vomiting episodes [sic] this week by patient. Unsure if it was related to dysphagia or excess mucous from respiratory symptoms ..."

Surveyor then observed an order placed on 01/15/2025 for Resident 5 to receive a minced and moist diet.

At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Director of Nursing K reported that Resident 5's bed rail use was meant to assist with his/her bed mobility. Both reported understanding of Surveyor's concern that Resident 5's ISP was not updated to reflect his/her dietary texture orders (minced and moist food) as well as information regarding his/her bed rail use.

Example 4 - Resident 6's fall-related supervision

On 01/28/2025, at approximately 10:10 a.m., Surveyor interviewed Caregiver H regarding residents' needs. Caregiver H reported that Resident 6 was known to have falls and be at risk for falling. Caregiver H reported that Resident 6 was known to not reliably ask for assistance in cares, though s/he was supposed to receive standby assistance of staff for all cares. Caregiver H reported that Resident 6 had a wrist call light with a small sticky note on it to remind him/her to use it to request staff assistance but

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 _____	R 01/31/2025

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 389	Continued From page 22	N 389		

that Resident 6 was still known to not use his/her call light reliably. Caregiver H reported that Resident 6 was on 2-hour safety checks which was the same as every other resident. Caregiver H reported that Resident 6 was also known to not ask for help after s/he had fallen and would typically only be found by staff after a fall during their safety checks. Caregiver H reported that after one recent fall at the end of December, Resident 6 had dislocated his/her finger and had a head contusion which required hospitalization. Caregiver H reported that s/he tried to keep Resident 6 in the common area for increased supervision but that this wasn't something s/he was instructed to do and s/he wasn't sure if other staff were doing this when s/he wasn't working. Caregiver H reported being unaware of any specific interventions staff were instructed to implement to mitigate Resident 6's fall risk.

On 01/28/2025, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 12/20/2023 with diagnoses including major neurocognitive disorder, vascular dementia, orthostatic hypotension, and repeated falls. Resident 6 was documented as having an activated power of attorney for healthcare. In reviewing Resident 6's progress notes, Surveyor observed the following notes related to 4 falls s/he experienced:

- Incident entry on 11/13/2024 which documented a witnessed fall that occurred that day at 12:50 p.m. The entry documented, " ...i [sic] saw as resident began to walk to another area when [s/he] began to stumble, lost balance and fell to the floor, resident later stated that [s/he] was not in any other pain than [his/her] head and that [s/he] was having trouble seeing out of [his/her] right eye ...resident was later seen by [emergency

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 _____	R 01/31/2025

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 389	Continued From page 23	N 389		

medical technician] where [s/he] was assed [sic]." The fall was documented as having occurred in the living room.

- An entry on 11/15/2024, indicating a "late entry" for 11/13/2024 from Resident 6's hospice nurse documented that Resident 6 underwent a post-fall assessment and that "frequent checks" were recommended "to ensure needs are met and safety."

- Incident entry dated 11/19/2024 which documented a witnessed fall that occurred on 11/16/2024 at 12:00 p.m. The entry documented that the fall occurred in the dining room and, "resident said [s/he] was trying to get up and lost balance." The fall was documented as having occurred in the dining room. Another entry that day documented that as part of post-fall follow up, "Writer discussed with resident the importance of using [his/her] call light prior to transferring and provided fall prevention education."

- 12/23/2024: "Staff placed call to triage nurse at 7:05 pm to report the resident has fallen and [s/he] will be sent to [local hospital]. Staff reports the fall was unwitnessed, but the resident was injured. Staff reports the resident disclosed that [s/he] was walked into the bathroom with [his/her] walker, tried taking [his/her] pants down and fell. Staff reports a skin break to the left side of the resident's head, skin tear located on the left arm and [his/her] left finger could be potentially broken ..." An entry on 12/24/2024 at 12:49 p.m. documented that resident remained hospitalized. An entry on 12/28/2024 documented that a new order was received for wound care to be initiated to Resident 6's left arm.

- 01/24/2025: "Resident had a fall this morning at

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 _____	R 01/31/2025

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 389	Continued From page 24	N 389		

7:30 [s/he] did hit [his/her] head on the left side. A bump is visible on [his/her] forehead ..."

- 01/26/2025: " ...Fall interventions initiated including hospital bed with half rail, fall mat which will be used at night and pushed under the bed during the day and a bedside commode."

Surveyor reviewed a hospice nursing note located within Resident 6's record, dated 01/14/2025, which documented: " ...patient has wound on [his/her] left forearm that has resolved and wound and left forehead is scabbed over, skin intact at this time ...[S/he] has some discomfort in [his/her] left ring finger, this was dislocated during [his/her] fall on December 22.Slight [sic] amount of bruising and knuckle appears swollen." Surveyor observed that this seemed to corroborate the 12/23/2024 progress note above detailing the injuries Resident 6 sustained after a fall, as well as Caregiver H's report.

Surveyor reviewed Resident 6's current ISP, dated 10/18/2024 (prior to Resident 6's most recent 4 falls). There was no information about his/her fall-related needs. The ISP documented that Resident 6 was on safety checks 2-3x/day, which Surveyor observed to be less frequently than the 2-hour checks Caregiver H had reported was standard for all residents. Surveyor did not observe any interventions directing implementation of "frequent checks" as recommended by Resident 6's hospice team on 11/13/2024 to mitigate his/her fall risk.

At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported understanding Surveyor's concern that there was not information about Resident 6's fall risk and fall risk mitigation

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 _____	R 01/31/2025

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 389	Continued From page 25 interventions documented in his/her ISP and that it wasn't clear if increased supervision, as described being utilized without specific parameters/guidelines by Caregiver H, and recommended by Resident 6's hospice team, was an intervention that was being implemented by all staff or just by Caregiver H since there were no defined documented parameters with it.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plans (ISPs) for Resident 2, Resident 4, and Resident 6, who were prescribed as needed	N 408		

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 _____	R 01/31/2025

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 408	Continued From page 26 (PRN) psychotropic medication, included the rationale for use and a detailed description of the behaviors indicating the need for their administration. This is a repeat deficiency. See Statement of Deficiency (SOD) FF1V11, dated 08/16/2024. Findings include: Example 1 - Resident 2's lorazepam On 01/28/2025, at approximately 10:43 a.m., Surveyor reviewed the medication cart with Clinical Coordinator L. Surveyor observed the following for Resident 2: - 1 card of PRN lorazepam 0.5 mg tablets, dispensed on 05/17/2024. The pharmacy label directions included, "Take 1 tablet by mouth every 4 hours as needed for agitation," and indicated that 30 tablets were part of the card. Two of the tablets were observed punched out. - 1 card of PRN lorazepam 0.5 mg tablets, dispensed on 05/09/2024. The pharmacy label directions included, "Take 1 tablet by mouth every 4 hours as needed for anxiety/agitation," and indicated that 30 tablets were part of the card. All 30 tablets were observed. - 1 card of PRN lorazepam 0.5 mg tablets, dispensed on 09/12/2024. The pharmacy label directions included, "Take 1 tablet by mouth every 4 hours as needed for agitation and anxiety *hospice patient*" and indicated that 30 tablets were part of the card. All 30 tablets were observed. - 1 card of PRN lorazepam 0.5 mg tablets,	N 408		

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 _____	R 01/31/2025

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N 408	Continued From page 27	N 408		

dispensed on 09/24/2024. The pharmacy label directions included, "Take 1 tablet by mouth every 4 hours as needed for agitation and anxiety *hospice patient*" and indicated that 60 tablets were part of the card. All 60 tablets were observed.

On 01/28/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 10/25/2021 with diagnoses including Alzheimer's dementia, depression, and anxiety disorder. Resident 2 was documented as having an activated power of attorney for healthcare. Resident 2's prescriptions included lorazepam 0.5 mg tablets with instructions to, "Take 1 tablet by mouth every 4 hours as needed for agitation and anxiety *hospice patient*." Surveyor reviewed the 2 most recent individual service plans (ISPs) for Resident 2, the first dated 10/18/2024 and the current one dated 01/02/2025. In the ISP dated 10/18/2024, the following was documented regarding his/her behaviors and behavioral needs:

- "Document number of behaviors per shift.. Follow responsive behavior plan.. The community to provide assistance to monitor reactive behaviors in a supportive environment."

In the ISP dated 01/02/2025, the following was documented regarding his/her aggressive behaviors and behavioral needs:

- Service type: "Behavior: More than 5x/week," which documented, "DOCUMENT NUMBER OF BEHAVIORS THROUGHOUT THE SHIFT, REPORT CONCERNS TO [power of attorney (POA)].. Community to provide behavior monitoring."

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 _____	R 01/31/2025

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N 408	Continued From page 28	N 408		

- Service type: "Behavior: Plan Eval," which documented, "Evaluate the behavior management plan to assure that the plan is meeting resident's needs. Update Service Plan and interventions as needed, notify POA of changes."

- Service type: "Behavior: Management Plan" which documented the same information as Resident 2's 10/18/2024 ISP (documented above).

Surveyor did not observe in either ISP information regarding Resident 2's PRN lorazepam or a detailed description of his/her behaviors that indicated the need for its administration.

At approximately 2:00 p.m., Surveyor requested Resident 2's behavior management plan (as referenced from his/her ISP as well as referenced in his/her 12/03/2024 observation note entry) from Business Office Manager J.

At approximately 2:20 p.m., Surveyor interviewed Business Office Manager J. Business Office Manager J reported that there really wasn't a specific behavior management plan but that the "plan" referenced a series of interventions staff were expected to utilize prior to administering Resident 2 his/her as needed (PRN) psychotropic medication. Business Office Manager J then provided Surveyor the "plan" which was a page of Resident 2's MAR documenting his/her PRN lorazepam administration. The prescription order was to take 1 tablet every 4 hours as needed "for agitation and anxiety *hospice patient* anxiety only: must attempt 3 interventions first, if not effective call...for permission to give." The interventions listed were "1-Talking with resident, 2-Quiet environment, 3-Toileting/check and

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 _____	R 01/31/2025

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TALAMORE SENIOR LIVING SUN PRAIRIE	275 NORTH CITY DRIVE SUN PRAIRIE, WI 53590

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N 408	Continued From page 29	N 408		

change." Business Office Manager J also reported that there was not a separate behavior log where staff documented the number of behaviors per shift and that this was tracked through the same MAR entry when Resident 2 was administered his/her PRN lorazepam. In then reviewing the MARs for Resident 2 from 11/01/2024 - 01/28/2025, Surveyor observed 2 administrations of PRN lorazepam - one tablet on 11/17/2024 at 2:51 p.m. for "anxiety" (no correlating behaviors documented in the MAR or progress notes), and one tablet on 11/23/2024 at 5:45 p.m. for "anxiousness, combati[veness]."

At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported understanding of Surveyor's concern that a detailed description of the behaviors warranting administration of Resident 2's PRN lorazepam was not identified in his/her ISP.

Example 2 - Resident 4's quetiapine

On 01/28/2025, at approximately 10:43 a.m., Surveyor reviewed the medication cart with Clinical Coordinator L. Surveyor observed the following for Resident 4:

- 1 card of PRN quetiapine 25 mg tablets, dispensed on 11/02/2024. The pharmacy label directions included, "Take 1/2 tablet (12.5 mg) by mouth twice daily as needed for anxiety / agitation due to major depressive disorder," and indicated that 15 tablets were part of the card (30 separate half-tablets). Seven half-tablets were observed punched out.

- 1 card of PRN quetiapine 25 mg tablets, dispensed on 12/05/2024. The pharmacy label

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 _____	R 01/31/2025

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 408	Continued From page 30	N 408		

directions included, "Take 1/2 tablet (12.5 mg) by mouth twice daily as needed for anxiety / agitation due to major depressive disorder," and indicated that 15 tablets were part of the card (30 separate half-tablets). All tablets were observed.

- 1 card of PRN quetiapine 25 mg tablets, dispensed on 05/21/2024. The pharmacy label directions included, "Take 1/2 tablet (12.5 mg) by mouth twice daily as needed for anxiety / agitation," and indicated that 15 tablets were part of the card (30 separate half-tablets). Five half-tablets were observed punched out.

On 01/28/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 10/04/2021 with diagnoses including major neurocognitive disorder and depression. Resident 4 was documented as having an activated POA for healthcare. Resident 4's prescriptions included quetiapine 25 mg tablets with instructions to, "Take1/2 tablet (12.5 mg) by mouth twice daily as needed for anxiety / agitation due to major depressive disorder." Resident 4's current ISP, dated 10/18/2024, documented the following regarding his/her behaviors:

- Service type: "Behavior: More than 5x/week," which documented, "Document # of behaviors per shift, document what the behavior was in the note section and answer redirectable question ..."

- Service type: "Behavior: Plan Eval," which documented, "Nurse to complete. Evaluate the behavior management plan to assure that the plan is meeting resident's needs. Update Service Plan and interventions as needed, notify POA of changes."

A "care plan" document of the same date also

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 _____	R 01/31/2025

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 408	Continued From page 31	N 408		

documented the above as well as the intervention, "Staff to redirect when [Resident 4] becomes combative, agitated, anxious, disoriented or displays any other unsafe behaviors."

Surveyor did not observe in either ISP information regarding Resident 4's PRN quetiapine or a detailed description of his/her behaviors that indicated the need for its administration.

At approximately 2:00 p.m., Surveyor requested Resident 4's behavior management plan (as referenced from his/her ISP) from Business Office Manager J.

At approximately 2:20 p.m., Surveyor interviewed Business Office Manager J. Business Office Manager J reported that there really wasn't a specific behavior management plan but that the "plan" referenced a series of interventions staff were expected to utilize prior to administering Resident 4 his/her as needed (PRN) psychotropic medication. Business Office Manager J then provided Surveyor the "plan" which was a document describing the same information above from his/her ISP and "care plan" document. Business Manager J also provided Surveyor a "Medication Passing Detail" document which documented recent administrations of Resident 4's PRN quetiapine. The document showed that 1/2 tablets were administered on 12/05/2024, 12/20/2024, and 12/23/2024 with the "Reason Given" documented as, "MAJOR DEPRESSIVE DISORDER."

On 01/28/2024, Surveyor reviewed Resident 4's progress notes, which did not document anything on the above 3 days regarding behaviors Resident 4 was demonstrating relating to his/her

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 408	Continued From page 32	N 408		

quetiapine administration.

At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported understanding of Surveyor's concern that a detailed description of the behaviors warranting administration of Resident 4's PRN quetiapine was not identified in his/her ISP.

Example 3 - Resident 6's haloperidol, lorazepam, and quetiapine

On 01/28/2025, at approximately 10:43 a.m., Surveyor reviewed the medication cart with Clinical Coordinator L. Surveyor observed the following for Resident 6:

- 1 card of PRN haloperidol 0.5 mg tablets, dispensed on 11/27/2024. The pharmacy label directions included, "Take 1 tablet by mouth every 4 hours as needed for anxiety or nausea/vomiting or hallucinations. Use first line for nausea/vomiting also can be used as needed for anxiety or hallucinations," and indicated that 20 tablets were part of the card. All tablets were observed.

- 1 card of PRN haloperidol 0.5 mg tablets, dispensed on 09/26/2024. The pharmacy label directions included, "Take 1 tablet by mouth every 4 hours as needed for anxiety or nausea/vomiting or hallucinations. Use first line for nausea/vomiting also can be used as needed for anxiety or hallucinations," and indicated that 20 tablets were part of the card. One tablet was punched out.

- 1 card of PRN lorazepam 0.5 mg tablets, dispensed on 12/20/2023. The pharmacy label

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 _____	R 01/31/2025

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 408	Continued From page 33	N 408		

directions included, "Take 1 tab by mouth every 3 hours as needed anxiety, restlessness, nausea," and indicated that 6 tablets were part of the card. All tablets were observed.

- 1 card of PRN lorazepam 0.5 mg tablets, dispensed on 01/23/2024. The pharmacy label directions included, "Take 1 tab by mouth every 3 hours as needed anxiety, restlessness, nausea," and indicated that 30 tablets were part of the card. All tablets were observed.

- 1 card of PRN lorazepam 0.5 mg tablets, dispensed on 11/27/2024. The pharmacy label directions included, "Take 1 tablet by mouth every 4 hours as needed for anxiety, nausea, or restlessness ..." and indicated that 20 tablets were part of the card. All tablets were observed.

On 01/28/2025, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 12/20/2023 with diagnoses including major neurocognitive disorder, vascular dementia, and major depressive disorder. Resident 6 was documented as having an activated POA for healthcare. In reviewing Resident 6's list of current medications, Surveyor observed the following:

- Haloperidol 0.5 mg tablets, with the same instructions as observed by Surveyor on his/her medication cards

- Lorazepam 0.5 mg tablets, with instructions to, "Take 1 tablet by mouth every 4 hours as needed for anxiety, nausea, or restlessness ..."

- Quetiapine 25 mg tablets, with instructions to, "Take 1 tablet by mouth at bedtime as needed for agitation."

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 _____	R 01/31/2025

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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 408	Continued From page 34 Resident 6's current ISP, dated 10/18/2024, documented the following regarding his/her behaviors: - Service type: "Behavior: less than weekly," which documented, "HISTORY OF DEPRESSION, DEMENTIA, PLEASE DOCUMENT BEHAVIORS T/O SHIFT, REPORT CHANGES IN [electronic platform] OR NURSE. REDIRECT AS APPROPIRATE [sic]. PLEASE DOCUMENT BEHAVIORS T/O SHIFT, REPORT CHANGES IN [electronic platform] AND NOTIFY NURSE SUPERVISOR.. Community to provide behavior monitoring." A separate "care plan" document of the same date documented that Resident 6's "behavior will be recorded on the behavior monitoring log" as well as the following interventions: "Complete behavior documentation throughout shift ...Staff to redirect when [Resident 6] becomes combative, agitated, anxious, disoriented, or displays any other unsafe behaviors." Surveyor did not observe in the ISP or care plan information regarding Resident 4's PRN haloperidol, lorazepam, or quetiapine, including a detailed description of his/her behaviors that indicated the need for the administration of each one. At approximately 3:48 p.m., Surveyor interviewed Business Office Manager J and Director of Nursing K. Both reported understanding of Surveyor's concern that a detailed description of the behaviors warranting administration of and distinguishing the use of Resident 6's PRN haloperidol, lorazepam, and quetiapine was not identified in his/her ISP.	N 408		

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 _____	R 01/31/2025

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