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-C 09/02/2025

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 08/21/2025, with information obtained through 09/02/2025, the Bureau of Assisted Living, Southern Regional Office, conducted two complaint investigations and 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, 1 deficiency was identified. Both complaints were unsubstantiated. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 26	{N 000}		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 3's legal representative was notified when there was an allegation that s/he was being physically abused by Caregiver O. Findings include: On 08/21/2025, Surveyor reviewed records from	N 170		

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

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N 170	Continued From page 1 the provider detailing an allegation of caregiver misconduct. The records indicated that the allegation was made on 06/12/2025 and that it specifically involved Person O having "proof of [Caregiver O] hitting [Resident 3]..." On 08/21/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 12/05/2022 with diagnoses including Alzheimer's disease and vascular dementia. Resident 3 was documented as having an activated power of attorney (POA) for healthcare. In reviewing the provider's records regarding the allegation again, Surveyor did not find any evidence that Resident 3's POA was notified of the allegation that Resident 3 was physically abused by Caregiver O. On 09/02/2025, at approximately 1:30 p.m., Surveyor interviewed Director of Nursing K and Administrator Q. Director of Nursing K reported that Resident 3's POA was not notified of the allegation. In reviewing the notification regulation with Director of Nursing K and Administrator Q, Director of Nursing K reported s/he had just been going off of guidance from the provider's human resources staff and only thought residents' legal representatives had to be notified if allegations against residents were substantiated.	N 170		