STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 From 07/24/2025 to 07/28/2025, Surveyor conducted a standard survey at Brookdale Sun Prairie, a CBRF in Sun Prairie. Eight deficiencies were identified. Three deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) YWN011, dated 03/17/2023, XREV11, dated 06/14/2023, SOD YWN012, dated 09/06/2023 and SOD VXR511, dated 04/04/2024. Census: 13	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 caregivers reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment. Caregiver D did not have a completed	N 220		

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
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 220	Continued From page 1 tuberculosis test within 90 days before the start of employment. This is a repeat deficiency. See Statement of Deficiency (SOD) YWN011, dated 03/17/2023 and SOD YWN012, dated 09/06/2023. Findings include: On 07/24/2025 at 9:00 a.m., Surveyor reviewed the employee record of Caregiver D, provided by Administrator A. The record indicated Caregiver D was hired on 01/20/2025 and had a tuberculosis test initiated on 01/24/2025. The record did not include the results of the tuberculosis test. On 07/24/2025 at approximately 9:30 a.m., Surveyor interviewed Administrator A and asked if s/he had the results of Caregiver D's tuberculosis test. Administrator A stated s/he was working with the clinic to obtain the results. On 07/25/2025 at 3:45 p.m., Surveyor received documentation from Administrator A that indicated Caregiver D did not have his/her tuberculosis test read so the provider did not have documented results. On 07/28/2025 at 12:20 p.m., Administrator A followed up with Surveyor and confirmed Caregiver D did not have a completed tuberculosis test. Administrator A stated Caregiver D would be removed from the schedule until a new tuberculosis test had been placed and read.	N 220		
N 381	83.35(1)(a) Pre-admission and ongoing assessments.	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 381	Continued From page 2 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 record review and interview, the provider did not ensure 1 of 3 residents reviewed had his/her needs and abilities assessed when there was a change. Resident 3 was not assessed for a change in need after sustaining a fall. Findings include: DHS Chapter 83 defines "Assessment" as a means of gathering and analyzing information about a prospective or existing resident's needs and abilities. On 07/24/2025 at 9:30 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 01/17/2023 with diagnosis of dementia. Resident 3's progress notes, dated 04/01/2025 to 07/24/2025 documented Resident 3 sustained an unwitnessed fall on 07/04/2025 while trying to tidy his/her bed. The record documented Resident 3 did not sustain an injury. Documentation did not include an assessment to determine if Resident	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 381	Continued From page 3 1's needs had changed to prevent further falls. On 07/24/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A and asked if Resident 3 had an updated assessment following his/her 07/04/2025 fall to determine if his/her needs had changed. Administrator A stated there was not a new assessment as far as s/he knew. On 07/25/2025 at 3:25 p.m., Administrator A stated s/he was advised there was a "Alert Post Fall Follow Up" progress note that s/he would use moving forward. Administrator A stated since his/her LPN had been let go at the time of Resident 3's fall, Administrator A did a verbal follow up regarding pain and had staff monitor for injury, but an assessment regarding an intervention had not occurred.	N 381		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 407	Continued From page 4 had their use of scheduled psychotropic medications reassessed by a pharmacist, practitioner or registered nurse at least quarterly. Resident 1's Quetiapine and Sertraline use was not reassessed quarterly by a pharmacist, practitioner or registered nurse. Resident 2's Olanzapine and Escitalopram use were not reassessed quarterly by a pharmacist, practitioner or registered nurse. Findings include: On 07/24/2025 at 9:30 a.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 1: Resident 1 was admitted to the provider's facility on 08/16/2024 with diagnoses including dementia, depression and anxiety. Resident 1's physician orders included Sertraline Hcl 50 mg daily (Start Date: 08/17/2024) and Quetiapine 25 mg 2 times daily (Start Date: 08/16/2024 through 06/06/2025). On 07/24/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 1's scheduled psychotropic reviews with Administrator A. Records documented Resident 1's Quetiapine use was reviewed once on 02/14/2025 by a RN; indicating the Quetiapine use was not reassessed quarterly. Resident 1's record indicated his/her Sertraline use was reviewed 04/22/2025 by a LPN, indicating the Sertraline use was not reassessed quarterly and was never reassessed by a pharmacist, practitioner or registered nurse.	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 407	Continued From page 5 Example 2 - Resident 2: Resident 2 was admitted to the provider's facility on 02/07/2023 with diagnosis of Alzheimer's disease. Resident 2's physician orders included Escitalopram 20 mg daily (Start Date: 08/23/2023) and Olanzapine .5 mg 2 times daily (Start Date: 10/20/2023). On 07/24/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 2's scheduled psychotropic reviews with Administrator A. Records documented Resident 2's scheduled Olanzapine use was reviewed on 01/19/2025 and 04/22/2025 by a LPN, indicating the Olanzapine use was not reassessed quarterly and was not reassessed by a pharmacist, practitioner or registered nurse. The records also indicated Resident 2's Escitalopram use was not reviewed. On 07/24/2025 at approximately 11:00 a.m., Surveyor reviewed concern with Administrator A that the use of scheduled psychotropic medications had not been reviewed quarterly by a pharmacist, practitioner or registered nurse. Administrator A agreed with Surveyor's concern and stated s/he and the provider's registered nurse were working on getting all required documentation in order.	N 407		
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	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 6	N 408		

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 2 of 2 residents reviewed had the rationale for use and a detailed description of the behaviors indicating the need for administration of a PRN psychotropic medication documented in the individual service plan (ISP).

Resident 1's ISP did not include the use of his/her Lorazepam PRN.
Resident 2's ISP did not include the use of his/her Lorazepam PRN.

Findings include:

On 07/24/2025 at approximately 9:30 a.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 1:

Resident 1 was admitted to the provider's facility on 08/16/2024 with diagnoses including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 7 dementia, depression and anxiety. Resident 1's physician orders included Lorazepam .5 mg (Start Date: 08/16/2024) every 3 hours as needed for hospice related; anxiety, nausea; restlessness. Resident 1's Medication Administration Record (MAR), dated 06/01/2025 to 07/24/2025, documented s/he received Lorazepam PRN on 06/19/2025, 07/21/2025 and 07/23/2025. Resident 1's ISP, dated 12/22/2024, did not document the use of his/her Lorazepam PRN. On 07/24/2025 at 10:00 a.m., Surveyor reviewed concern with Administrator A that PRN psychotropic use was not included in Resident 1's ISP. Administrator A stated the provider's RN had Resident 1's ISP on a list to update. Example 2 - Resident 2: Resident 2 was admitted to the provider's facility on 02/07/2023 with diagnosis of Alzheimer's disease. Resident 2's physician orders included Lorazepam .5 mg (Start Date: 04/08/2025) - 1 tablet every 8 hours as needed for agitation and anxiety. Resident 2's MAR, dated 07/01/2025 to 07/24/2025, indicated s/he received Lorazepam PRN on 07/11/2025 and 07/21/2025. Resident 2's ISP, dated 12/22/2024, did not document the use of his/her Lorazepam PRN. On 07/24/2025 at 10:00 a.m., Surveyor reviewed concern with Administrator A that PRN psychotropic use was not included in Resident 2's ISP. Administrator A stated the provider's RN had Resident 2's ISP on a list to update.	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 431	Continued From page 8	N 431		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed had their health monitored with changes documented in his/her record. Resident 1's blood pressure was not monitored and recorded twice daily as ordered. This is a repeat deficiency. See Statement of	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 431	Continued From page 9 Deficiency (SOD) XREV11, dated 06/14/2023 and VXR511, dated 04/04/2024. Findings include: On 07/24/2025 at approximately 9:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 08/16/2024 with diagnosis of hypertension. Resident 1's physician orders included Metoprolol Tartrate 25 mg (Start Date: 08/16/2024) - Take 1 tablet 2 times daily; hold if systolic blood pressure is below 110. Resident 1's medication administration record (MAR), dated 06/01/2025 to 07/24/2025, documented administration of Resident 1's Metoprolol but did not document a blood pressure reading for the following dates: 06/02/2025 PM, 06/08/2025 PM, 06/09/2025 PM, 06/16/2025 PM, 06/21/2025 PM, 06/23/2025 PM, 06/30/2025 PM, 07/05/2025 PM, 07/06/2025 AM and PM, 07/07/2025 PM, 07/08/2025 PM, 07/12/2025 PM, 07/14/2025 PM, 07/19/2025 PM, 07/20/2025 PM and 07/21/2025 PM. On 07/24/2025 at approximately 10:45 a.m., Surveyor reviewed concern with Administrator A that Resident 1's record did not include blood pressure readings as ordered when his/her Metoprolol was due. Administrator A reviewed Resident 1's record and stated, "You are correct." Administrator A stated s/he was unable to locate blood pressure readings for the dates Surveyor identified above.	N 431		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 452	Continued From page 10 conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure their freezing unit maintained a temperature of 0 degrees F or below. Findings include: On 07/24/2025 at 11:18 a.m., Surveyor observed the temperature of the freezer was 18 degrees F. Cook B stated the freezer was known to increase in temperature when it was auto defrosting. Surveyor observed ice cream partially melted and a cardboard box containing ice build up in the freezer. Cook B stated s/he had the cardboard box placed under a hose that leaked when the freezer auto-defrosted. Surveyor placed his/her own thermometer in the freezer. At 11:38 a.m., Surveyor observed his/her thermometer had a temperature of 31 degrees. Surveyor shared observation with Administrator A.	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 452	Continued From page 11 Administrator A stated s/he was unaware of the leak and requested that Cook B dispose of the ice cream. Administrator A stated the freezer had been serviced on 03/05/2025 and 03/21/2025 and s/he was unaware of continued issues. Administrator A stated s/he would put in a maintenance request for the freezer.	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a clean and homelike environment was provided. Resident bathrooms were not clean. Soiled laundry was observed on the floor. Alarms were at a noise level that was not homelike and could invoke fear. This is a repeat deficiency. See Statement of Deficiency (SOD) YWN012, dated 09/06/2023. Findings include: On 07/24/2025, Surveyor conducted a standard survey and identified the following concerns: Bathrooms: At approximately 7:45 a.m., Surveyor toured resident rooms and observed Resident 3,	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 481	Continued From page 12 Resident 4, Resident 5, Resident 6 and Resident 7's toilets had brown, gray and black build up around the water line (Photo 1, Photo 2 and Photo 3). At approximately 11:00 a.m., Surveyor interviewed Administrator A and shared concern regarding the lack of cleanliness in resident bathrooms. Administrator A reviewed Surveyor's photos and stated s/he would expect bathrooms to be cleaner than Surveyor observed and that s/he would address the concern. Laundry: At approximately 7:53 a.m., Surveyor observed a laundry basket full of soiled laundry on Resident 5's bedside table and a pile of soiled bedding on the floor. Resident 5's room had a strong odor of urine. At approximately 11:00 a.m., Surveyor interviewed Administrator A and shared concern regarding Resident 5's soiled laundry on the floor. Administrator A stated s/he would look into adding an additional laundry day for Resident 5. Alarms: From 7:49 a.m. to 8:01 a.m., Surveyor heard a loud alarm continuously beeping. The alarm could be heard from all areas of the facility and made conversations difficult to have in the kitchen, where the sound originated from. At 8:00 a.m., Surveyor interviewed Cook B and asked what the constant alarm was. Cook B stated the alarm was a resident's call light. At approximately 10:25 a.m., Surveyor heard	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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 481	Continued From page 13 another alarm that was a constant, loud beeping. Surveyor was sitting with Administrator A, who acknowledged the volume of the alarm and stated it was due to the front door being open longer than the allotted time. Surveyor shared concern that the provider's call light alarm was also very loud. Administrator A agreed with Surveyor and stated s/he wished the alarms weren't near as loud as they were. Administrator A shared concern that the alarm could invoke fear or behaviors from their residents who had dementia.	N 481		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident was treated with courtesy, respect and full recognition of his/her	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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
Y3234	Continued From page 14	Y3234		

dignity and individuality. Resident 3 received assistance ambulating in the hallway while wearing only his/her depends on the lower half of his/her body. Residents had to wait greater than 1 hour to be served breakfast while other residents sitting nearby were served.

Findings include:

On 07/24/2025, Surveyor conducted a standard survey and observed the following concerns:

Example 1 - Cares:

On 07/24/2025 at approximately 7:55 a.m., Surveyor went into Resident 6's room. Surveyor observed Resident 6 in bed and Resident 3 sitting in Resident 6's chair with only a pajama top and depends on. Resident 3's pants were resting on his/her walker. Resident 6 informed Surveyor that Resident 3 had come into Resident 6's room to use Resident 6's bathroom.

On 07/24/2025 at approximately 8:02 a.m., Surveyor observed Caregiver C provide standby assistance to Resident 3 as Resident 3 was redirected to his/her own room. Surveyor observed that Resident 3 was assisted through the hallway while wearing only his/her pajama top and depends.

On 07/24/2025 at approximately 11:00 a.m., Surveyor reviewed concern with Administrator A that Resident 3 was led through the hallway in only a pajama top and his/her depends. Administrator A made note of Surveyor's concern and replied, "Instead of being covered up?" Administrator A stated Resident 3 often wandered into others rooms and required redirection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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
Y3234	Continued From page 15 Dining: On 07/24/2025 at 7:40 a.m., Surveyor observed Resident 5 and Resident 7 sleeping at a dining room table. Surveyor observed Cook B preparing breakfast and caregivers providing care to other residents in resident rooms. On 07/24/2025 at 8:02 a.m., Surveyor observed Resident 4 and Resident 8 served a bowl of cereal. Resident 4 and Resident 8 were not served anything to drink with their cereal. Resident 5 and Resident 7 remained sleeping without any food. On 07/24/2025 at 8:25 a.m., Surveyor observed Resident 4 served eggs and toast (the remaining items on the menu). Surveyor observed Resident 8 had left the table after finishing his/her cereal, with no milk and no other food. Resident 5 and Resident 7 remained sleeping without any food. On 07/24/2025 at 8:45 a.m., Surveyor observed Resident 5 and Resident 7 served food. Resident 7 received assistance from staff for eating. On 07/24/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A regarding the provider's breakfast routine. Administrator A stated breakfast was served to residents as they came out to the dining room, rather than at a specific time. Administrator A stated Cook B arrived to work at 7:30 a.m. and began preparing breakfast at that time. Surveyor shared concern that Resident 5 and Resident 7 were waiting at the table for greater than 1 hour while other residents were served around them. Administrator A stated Resident 7 would have needed a caregiver available to provide assistance with feeding, but Resident 5 was able	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110491	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SUN PRAIRIE	650 BROADWAY ST 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
Y3234	Continued From page 16 to feed him/herself.	Y3234		