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 _____	R 11/10/2025

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 On 11/10/2025, Surveyor conducted a verification visit at Brookdale Sun Prairie, a CBRF in Sun Prairie. Three deficiencies were identified. Two deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) XREV11, dated 06/14/2023, SOD VXR511, dated 04/04/2024 and SOD MZQ311, dated 07/28/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 12	{N 000}		
{N 381}	83.35(1)(a) Pre-admission and ongoing assessments. 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	{N 381}		

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 _____	R 11/10/2025

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 1 was a change. Resident 3 was not assessed for a change in need after sustaining a fall. This is a repeat deficiency. See Statement of Deficiency (SOD) MZQ311, dated 07/28/2025. 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 11/10/2025 at 10:00 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 record included documentation of an unwitnessed fall in his/her bathroom on 10/06/2025. The report documented that there was no apparent injury, vitals were taken and involved parties notified. Documentation did not include an assessment to determine if Resident 3's needs had changed to prevent further falls. On 11/10/2025 at approximately 10:30 a.m., Surveyor interviewed Health and Wellness Director E and asked if Resident 3 had an updated assessment following his/her 10/06/2025 fall to determine if his/her needs had changed. Health and Wellness Director E replied, "No. [His/her] vitals were just checked." Health and Wellness Director E stated there wasn't really anything the provider could do for Resident 3. Health and Wellness Director E later stated s/he did explore hospice eligibility for Resident 3, but Resident 3 reportedly didn't meet criteria.	{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 _____	R 11/10/2025

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 2	{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.	{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 _____	R 11/10/2025

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 3 Resident 1's blood pressure was not monitored and recorded twice daily as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) XREV11, dated 06/14/2023, SOD VXR511, dated 04/04/2024 and SOD MZQ311, dated 07/28/2025. Findings include: On 11/10/2025 at approximately 10:30 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 10/02/2025 to 11/10/2025, documented administration of Resident 1's Metoprolol but did not document a blood pressure reading for the following dates: 10/08/2025 AM, 10/09/2025 AM, 10/11/2025 AM, 10/12/2025 AM, 10/12/2025 PM, 10/15/2025 AM, 10/16/2025 PM, 10/20/2025 PM, 10/22/2025 AM, 10/23/2025 AM, 10/25/2025 AM, 10/29/2025 AM, 10/30/2025 AM, 11/05/2025 AM, 11/06/2025 AM and 11/08/2025 AM. On 11/10/2025 at approximately 10:45 a.m., Surveyor reviewed concern with Health and Wellness Director D that Resident 1's Metoprolol was documented several times without a corresponding blood pressure documented. Health and Wellness Director D stated s/he audited resident MARs but should probably do so more frequently.	{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 _____	R 11/10/2025

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 441	Continued From page 4	N 441		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each employee followed hand washing procedures according to Centers for Disease Control and Prevention (CDC) standards. Caregiver C and Caregiver F did not wash or sanitize their hands or change gloves after assisting residents with eating and/or touching resident food. Findings include: The Centers for Disease Control and Prevention (CDC) published the following article on 02/27/2024: "Clinical Safety: Hand Hygiene for Healthcare Workers" (https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html). This guideline details the standard for caregivers regarding glove use and hand washing to prevent the spread of infections. The CDC has recommended that caregivers change gloves and clean hands when moving from care on one patient to another patient. On 11/10/2025 from 8:00 a.m. to 9:00 a.m., Surveyor observed caregivers in the dining room and observed the following concerns: - At 8:24 a.m., Caregiver C assisted Resident 7 with his/her breakfast. Caregiver C did not wear	N 441		

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 _____	R 11/10/2025

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 441	Continued From page 5	N 441		

gloves. While assisting Resident 7, Surveyor observed Caregiver C touching his/her own eyes and face. At 8:30 a.m., Surveyor observed Caregiver C rinse only his/her left hand with water. Caregiver C then obtained keys from another caregiver and walked down the hallway to use the bathroom.
- At 8:35 a.m., Caregiver C returned to the dining room and took Resident 5 and Resident 7's soiled dishes to the kitchen. Without washing his/her hands, Caregiver C gathered new utensils and napkins and placed them in front of Resident 5 and Resident 7. Caregiver C then gathered fresh water from a pitcher in the refrigerator for Resident 5 and Resident 7. Caregiver C then gathered additional food, served Resident 5 and Resident 7 and assisted Resident 7 with his/her meal. Throughout the duration of tasks, Caregiver C did not wear gloves or wash his/her hands.
- At 8:46 a.m., Surveyor observed Caregiver F sitting between Resident 2 and Resident 9 without gloves on. Surveyor observed Resident 2 required full assistance with eating and Resident 9 required intermittent assistance with eating. Surveyor observed Caregiver F assist Resident 2 by bringing food directly to his/her mouth and then load Resident 9's spoon and place Resident 9's hand over the spoon to hold. Caregiver F was also observed touching Resident 9's toast on multiple occasions. Caregiver F did not wear gloves or wash his/her hands between feeding Resident 9 and Resident 2.

On 11/10/2025 at 11:00 a.m., Surveyor reviewed hand hygiene concerns with Health and Wellness Director E. Health and Wellness Director E stated s/he would expect proper hand hygiene while feeding residents. Health and Wellness Director E

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 _____	R 11/10/2025

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 441	Continued From page 6 cringed when Surveyor shared that a caregiver directly touched resident food. Health and Wellness Director E stated s/he would follow up with caregiver education.	N 441		