STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018374	A. BUILDING: _____ B. WING _____	C 03/13/2026

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 03/13/2026, the bureau of assisted living southern regional office conducted 2 complaint investigations at Talamore Senior Living a CBRF located in Sun Prairie, WI. As a result of this survey, 1 violation of DHS Chapter 83 was identified. One of 2 complaints were substantiated. Census: 26	N 000		
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 Resident 1's individualized service plan (ISP) was reviewed and revised based on the assessment under sub. (1) when there was a change in his/her needs, nor had Resident 1 or his/her legal representative sign the ISP, acknowledging their involvement in,	N 389		

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

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understanding of and agreement with the ISP.

From 03/02/2025 to 08/15/2025, Resident 1 suffered 11 falls and received treatment for 4 wounds.

On 08/16/2025, Resident 1 fell from his/her wheelchair. Provider sent Resident 1 to an emergency room where s/he was admitted inpatient for treatment of mulitple facial fractures.

On 03/13/2026, Surveyor reviewed Resident 1's most recent ISP. The ISP wasn't signed by Resident 1 or his/her legal representative (Famliy Member D). The ISP was dated as "effective" on 07/16/2025. The ISP didn't contain documentation of Resident 1's fall history, wound history and/or related interventions.

This is a repeat from previous statement of deficiency (SOD) FF1V11 dated 08/16/2024 and FFIV12 dated 01/31/2025.

FINDINGS INCLUDE:

On 12/29/2025, the Department received a complaint related to cares provided by facility.

On 03/13/2026, Surveyor arrived at the facility for a complaint investigation.

RECORD REVIEW:

On 03/13/2026, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 12/20/2023. Resident 1 had an activated power of attorney (Family Member D). The durable medical equipment listed were EZ stand, hospital bed, wheelchair and adaptive silverware. Under the subsection titled,

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"NOTES/ALERTS," the following was documented, "Cognitively impaired, constant supervision needed ...".Resident 1 was admitted to a hospice service. Resident 1 was diagnosed with but not limited to: major neurocognitive disorder, dementia with behavioral disturbance, unspecified protein-calorie malnutrition, chronic obstructive pulmonary disease, paroxysmal atrial fibrillation, presence of cardiac pacemaker, syncope and collapse and hypertension.

On 03/13/2026, Surveyor reviewed Resident 1's facility progress notes from 03/02/2025 to 08/26/2025:

1.) On 03/02/2025 at 12:46 PM, Nurse H documented Resident 1 had an unwitnessed fall without injury.

2.) On 03/07/2025 at 6:44 PM, Nurse I documented the following, "Direct care staff contacted writer to report unwitnessed fall. Report resident sitting in chair and got up and tripped and sat on bottom ...".

3.) On 04/19/2025 at 7:30 AM, Previous Nurse E documented the following, "Focused visit performed d/t: F/u on concerns after LPN visit today - hypertension, new wound on L forearm, possible UTI, lung assessment, check R great tow for infection ...Follow-up needed: RN visit is needed 4/25 to assess hypertension, new wound on L forearm, check for possible UTI, lung assessment, check R great toe for possible infection ...".

4.) On 05/17/2025 at 8:27 AM, Nurse H documented the following, "7am- call received from staff stating that they received a phone call from residents (family member) with update that

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per camera resident had a fall. Staff went to check on resident and found resident lying on [his/her] back on the floor in the bathroom with BM (bowel movement) noted on the floor. [Resident 1] is unable to state how fall occurred or if [s/he] hit [his/her] head ...".

5.) On 05/20/2025 at 2:46 PM, Nurse J documented the following, "Wound care to R elbow to be completed 1x weekly by hospice and PRN ...1. Remove old dressing ...2. cleanse with wound cleanser ...3.skin prep to peri wound ...4. place foam dressing ...".

6.) On 05/28/2025 at 10:06 PM, Nurse K documented the following, "Call received from RA (resident assistant) at 10:06 PM to report resident was discharged from UW East post fall at approximately 4:45 PM. Xray and CT negative. Stitches present on right side of forehead near eye brow (sic.). No (sic.) swelling. Slight bruising present ...Staff to continue safety checks and report and changes to baseline such as weakness, headache, slurred speech, confusion, pain, swelling, or vision changes ...".

7.) On 06/02/2025 at 4:56 PM, Caregiver L documented Resident 1 suffered an unwitnessed fall. Resident 1 was found on the hallway floor holding his/her head. Staff assessed Resident 1 was bleeding from a "Gash in Head ...".

8.) On 06/05/2025 at 6:43 PM, Nurse I documented Resident 1 suffered an unwitnessed fall. Resident 1 was found sitting next to his/her bed. No, injury documented.

9.) On 06/07/2025 at 9:56 AM, Nurse H documented the following, " ...call received from staff stating that resident had a witnessed fall.

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N 389	Continued From page 4 Staff stated that resident was sitting in [his/her] w/c (wheelchair) dozing, started to lean forward and slid out of wheelchair onto the floor hitting the right side of [his/her] forehead on the floor. Large bump and medium sized open area noted to right side of forehead pressure to area but large amount of bleeding continues. Writer instructed staff to call 911 ...". 10.) On 06/07/2025 at 2:31 PM, Nurse H documented the following, " ...call received from [Hospice Nurse] stating that resident will be returning from the ER with new orders for Keflex as a preventative measure d/t stitches, all labs and CT scan came back negative ...". 11.) On 06/11/2025 at 7:30 AM, Previous Nurse E documented the following, "Late Entry for 6/6/2025 4:00 PM: New Order from [Doctor M] and Hospice: Wound care daily to left forehead to be performed by Nurse or Caregiver. Wound to consisit (sic.) or removal or old dressing, clean with wound cleanser, pat dry, lease open to air. Allow steri strips to fall off naturally. Discontinue wound care once steri strips call off ...". 12.) On 07/31/2025 at 11:45 AM, Previous Nurse E documented an email from Hospice Nurse N, " ...Patient tolerating new pureed diet well. Needs assistance with feeding occasionally but no choking or coughing noted since diet change. Patient feeding [himself/herself] during visit but occasionally needed assistance from [Family Member] ...". 13.) On 08/13/2025 at 10:34 AM, Triage Nurse O Documented Resident 1 suffered and unwitnessed fall. No, injury documented. 14.) On 08/15/2025 at 11:25 AM. Caregiver P	N 389		

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documented Resident 1 suffered a witnessed fall in the activity room. No, injury documented.

15.) On 08/16/2025 at 7:03 PM, Glost Nurse Q documented the following, "Direct care staff contacted writer at 18:54 and reported that resident had a fall in the common area. RA states that heard a loud bang so they came and found resident on the floor with [his/her] forehead bleeding and right eye swollen. Staff stated EMS (emergency medical service) was already there at the time of call and they were going to take resident to the [Name Of Local Hospital] ...".

16.) On 08/19/2025 at 8:33 AM, Previous Nurse E documented the following, "Writer spoke with [Name of Hospital Discharge Planner] who inquired whether we would accept resident back on hospice ...[Name of Hospital Discharge Planner] reports the following injuries were noted during hospitalization: ...Mildy displaced comminuted (sic.) fracture for the right lateral orbital wall ...right temporal bone fracture ...minimally displaced fractures of the posterior wall of the right maxillary sinus and lateral wall of the right sphenoid sinus with adjacent pneumocephalus ...minimally displaced bilateral nasal arch fractures ...large right periorbital hematoma..R3 mm subdural hematoma ...Chronic right humeral and chronic bilateral rib fractures ...Right frontal bone fracture ...".

17.) On 08/26/2025 at 9:48 PM, Nurse I documented the following, "Writer notified unwitnessed fall 9:20pm. Caregiver reports bed alarm went off, went to resident apartment and found resident learning (sic.) over chair in kitchen, staff also report talked to [Family Member] on phone and per camera resident was lying on floor next to bed on right side at 8:50pm, [Family

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Member] reports must of got [himself/herself] up off of floor, Caregivers report small cut to left hand pinky finger, cleansed and applied simple dressing ...".

On 03/13/2026, Surveyor reviewed Resident 1's hospice record. On 08/20/2025 at 8:44 PM, Hospice Nurse R documented the following, " ...Writer received confirmation from APOA [Family Member S]. Upon arrival to the facility, writer check in with facility [Previous Nurse C]. [Previous Nurse C] reports patient will now be hoyer only for transfers, as [s/he] was unable to ambulate in facility. [S/He] reports patient has several bruises from the fall ...[Family Member S] did speak to [Previous Nurse C] about concerns with facility staff leaving common areas unsupervised as well as safety measures within the facility ...".

On 03/13/2026, Surveyor reviewed Resident 1's ISP. Resident 1's ISP wasn't signed by Resident 1 or Family Member D. At the top of the first page of the ISP was documented, "Effective Date/Time: 07/16/25 12:00 AM ...". Under the subsection titled, "Ambulation," the following was documented, " ...Ambulation: Cueing/Standby Standby assisted with ambulation Unlicensed assistive personnel to support resident in independent ambulation through cueing and standby assist ...1 person assist for all transfers and ambulation ...". Under the subsection titled, "Assistive Devices," there was only documentation stating staff were responsible for cleaning Resident 1's assistive devices and did not list any of the adaptive equipment mentioned on facility facesheet (EZ stand, hospital bed, wheelchair). Under the subsection titled, "Skin Monitoring," it was documented that staff were to monitor his/her skin and report any concerns to

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N 389	Continued From page 7 the nurse but didn't mention the wounds Resident 1 obtained since 12/24/2024. Under the subsection titled, "Transfer Assistance," the following was documented, " ...Transfer: Cue/Stndby (sic.) 5+x/day 1 person assist with gait belt, pivot transfer ...Unlicensed personnel to cue and prompt resident through transfer. Assure mobility equipment as applicable is nearby before transfer ...". The ISP didn't contain documentation of a Resident 1's fall history or a fall risk prevention care plan for him/her. INTERVIEWS: On 03/13/2026 at 1:03 PM, Surveyor discussed the above concerns with Administrator A and Nurse B. Administrator A and Nurse B acknowledged Resident 1's ISP wasn't signed by Resident 1 or his/her activated power of attorney. Administrator A and Nurse B acknowledged Resident 1's ISP was dated as effective over a year ago. Administrator A and Nurse B acknowledged Resident 1's ISP wasn't updated with the multiple unwitnessed/witnessed falls s/he suffered from March 2025 until August 2025. Administrator A and Nurse B acknowledged Resident 1's ISP didn't document any form of fall prevention plan for Resident 1. Administrator A and Nurse B acknowledged Resident 1's ISP didn't document the wounds and/or orders for wound care treatment s/he required from March 2025 to August 2025. Administrator A and Nurse B acknowledged Resident 1's ISP didn't reflect his/her needs for: EZ stand for transfers, hospital bed when in room, or wheelchair for mobility.	N 389		