STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL 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 10/06/2025, Surveyor conducted a complaint investigation at Hyland Crossings. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See Statement of Deficiency (SOD) N5Q311, dated 05/24/2023. The complaint was substantiated. Census: 24	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review, and interview, the provider did not ensure each resident received prompt and adequate treatment appropriate to the resident's needs. Resident 1 experienced a change of condition. After 14 days, Resident 1 was seen by his/her primary care physician (PCP) and diagnosed with an acute kidney injury. From 07/09/2025 to 07/20/2025, staff recorded 7 occurrences of Resident 1's change of condition behaviors without receiving adequate medical treatment to meet his/her needs.	N 353		

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
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

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HYLAND CROSSINGS	1249 SCHOOL ST SUN PRAIRIE, WI 53590

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N 353	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) N5Q311, dated 05/24/2023. Findings include: On 08/25/2025, the Department received a complaint regarding resident treatment at the facility. On 10/06/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 08/31/2021 with diagnosis including Alzheimer's disease, seizures, and prediabetes. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 1's individual support plan (ISP) dated 08/07/2025 documented: "Unable to communicate needs: Residents is unable to communicate needs, verbally and or non-verbally. Staff observe for physical cues, grimacing, wincing, gazing at an item. Care Coordination: [Provider] staff will arrange appointments with beauty shop, podiatry, and the immunization clinic. I want and need [Provider] staff to schedule and arrange services provided by non-[Provider] staff as needed thru next review." Resident 1's progress notes documented: "-07/09/2025: Res is very upset this am. Writer went to assist res and [s/he] was sitting on [his/her] bed crying. I asked [him/her] what was wrong [s/he] stated [s/he] didn't know and that [s/he] didn't wont [sic] to be here. I offered to call a relatives or a snack and [s/he] stated no [s/he] will be just fine. Res is now out at [his/her] table coloring and having coffee. -07/12/2025: Writer noticed resident was holding head in hands during and refusing to eat. When	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 353	Continued From page 2	N 353		

writer asked resident what was bothering [s/he] was unable to answer clearly. Writer asked resident if [s/he] was experiencing any pain and [s/he] said yes. Writer gave resident PRN Tylenol. Writer helped toilet resident, changing into pajamas, and brush/floss teeth. Resident verbalized that [s/he] would like to lay in bed and rest.
-07/14/2025: The resident seems to have more difficulty seeing. When I was talking to [him/her] [s/he] seemed to have a hard time seeing and [s/he] asked where I was when I was standing directly in front of [him/her].
-07/15/2025: Resident has been more down and depressed lately, but after activities put videos of baby laughing [s/he] has been all smiles.
-07/17/2025: Resident was seen majority of they day with [his/her] head down and holding [his/her] head in [his/her] hands. Resident was approached multiple times, resident stated there was some pain but could not articulate where the source of pain is. PRN Tylenol given with some relief.
-07/18/2025: Resident walked to [his/her] room. Care staff took [him/her] to the bathroom. Resident walked into wall and stated [s/he] doesn't feel right. At this time [s/he] said [s/he] wasn't in pain but then getting into bed [s/he] almost fell out. Resident was holding [his/her] head at dinner. Care staff asked if [s/he] was okay [s/he] stated "I am not." When writer asked what was wrong [s/he] couldn't say what it was. [S/he] stated "I don't know." [S/he] did not eat [his/her] dinner.
-07/20/2025: Resident stood up from bed and was walking beside writer and started falling into the wall on L side of the bathroom. Resident started laughing saying "I don't know what's wrong with me, why am I doing this?" Resident could not follow directions. Ex: pull pants down,

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	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL ST SUN PRAIRIE, WI 53590

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N 353	Continued From page 3 sit down, take shoes off, etc. Resident still holding head in hands c/o pain and not feeling like [him/herself]. -07/21/2025: Writer sent POA an email update on how [his/her] [mom/dad] has been doing lately: 1. [S/he] is not eating, unless [s/he] has staff assistance. If and when [s/he] does start eating, [s/he] makes a face as if it hurts to eat. 2. When [s/he] stands up from [his/her] bed, [s/he] seems to be losing [his/her] balance and tends to lean toward the left side, which looks like [s/he] is falling into the wall. 3. [S/he] has not been coming out of [his/her] room, [s/he] has been laying in [his/her] bed all the time. 4. [S/he] places [his/her] hands on [his/her] head and says that there is something wrong, but [s/he] does not know what it is. 5. Tylenol has not been helping with any of [his/her] pain issues. Resident also had a fall about 3 hours prior, no injuries or pain noted. Writer asked POA if [s/he] could get an appt with PCP to see if anything more is going on with Resident. POA did call respond to email about trying to find an appt with PCP. Will keep us posted. -07/22/2025: POA called writer and did inform that family friend, will take Resident to see PCP on 7/24/25 at 10:15 am. Resident was complaining of headache tonight and being confused. [S/he] did a lot of squinting and rubbing [his/her] eyes. When asked if [s/he] was okay res stated no [s/he] not okay but was headed to bed. When pressed for what was not okay [s/he] stated [s/he] doesn't feel right. -07/23/2025: resident has not been [him/herself] in a few days, tonight [s/he] is isolated much more than the previous days. When asked if [s/he] was okay [s/he] stated [s/he] didn't feel right, [s/he] also has not been interacting with [his/her] friends as [s/he] used too. Writer sat and chatted with [him/her] a while and [s/he] stated	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL ST SUN PRAIRIE, WI 53590

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N 353	Continued From page 4 [s/he] felt a little better but still "didn't feel right." -07/24/2025: Resident went to UW Clinic..for an appointment..for falls and cognitive/behavior changes. Labs were done today, BMP and CBC along with a UA. Received a call from UW with lab results, stating that [s/he] is dehydrated and needs fluids, [s/he] has an acute kidney injury. UW contacted POA who is in Canada and [s/he] would like [him/her] sent via EMS to UW East Hospital, EMS contacted and awaiting their arrival. -07/25/2025: Resident was D/Ced ER last night after receiving IV fluids after labs came back showing acute kidney injury. ER recommends frequent reminders for adequate oral intake and hydration due to [his/her] dementia. Resident does not have a follow up appt with PCP office until 8/26/25 ...Per UW, "altered mental status is likely due to combination of poor oral intake and progressing dementia." Staff to continue to monitor resident, assist as needed. -07/30/2025: Resident returned to the [provider] via ambulance from UW Hospital. EMS brought Resident into [his/her] room and assisted to get [him/her] into [his/her] bed. Resident is now on hospice, please call with any changes, falls, or concerns. Resident is now a 2 assist with grooming, mobility, and dressing. [S/he] has a foley catheter that needs to be emptied throughout the day. Resident was in bed at the hospital. Resident has been sleeping a lot of the time, offer to feed [him/her] meals or give [him/her] an ensure to drink. Resident has no scheduled medications, everything is as needed, so make sure [s/he] is comfortable." Surveyor reviewed Resident 1's task administration record for July 2025. The following was found: -Behavior monitoring: Please monitor and	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL ST SUN PRAIRIE, WI 53590

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N 353	Continued From page 5	N 353		

document resident's behaviors for each shift. Resident has behavior expressions that require documentation and monitoring.
"-07/09/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? Paranoia, Anxiety, Depression/crying, withdrawn.
-07/13/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? 2 entries: Paranoia, Anxiety, Depression/crying, withdrawn.
-07/14/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? 3 entries: Depression/crying, withdrawn.
-07/15/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? 3 entries: Depression/crying, withdrawn, paranoia, anxiety.
-07/16/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? Depression/crying.
-07/17/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? 2 entries: withdrawn, aggression.
-07/18/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? Anxiety, depression/crying, delusions, withdrawn.
-07/19/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? Depression/crying, delusions, withdrawn.
-07/20/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? 2 entries: anger, anxiety, depression/crying, delusions, withdrawn.
-07/21/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? Paranoia, withdrawn.
-07/22/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? 2 entries: withdrawn, anxiety, depression/crying.
-07/23/2025: Did resident exhibit behaviors this

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	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL ST SUN PRAIRIE, WI 53590

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N 353	Continued From page 6	N 353		

shift? Yes. What behaviors did resident exhibit? Anxiety.
-07/24/2025: Did resident exhibit behaviors this shift? Yes. What behaviors did resident exhibit? Anxiety, delusions, withdrawn."

On 10/06/2025, Surveyor reviewed Resident 1's after visit summary dated 07/24/2025. The following was documented, "The following issues were addressed Falls, Cognitive and behavioral changes."

On 10/06/2025, Surveyor reviewed Resident 1's psychiatry follow up summary dated 07/10/2025. The following was documented:
"Staff note that overall resident pulling at shirt collar behavior has worsened over the past month. Staff also have a video of resident at an activity where [s/he] is not only pulling at [his/her] shirt collar but also picking at other areas of [his/her] body and clothing. [S/he] appeared internally preoccupied and was not following activity or cues. Skin picking and collar pulling behavior has now led to multiple open areas and scabs on her body.

On 10/06/2025, Surveyor reviewed the provider's notice of disciplinary action for LPN B dated 09/02/2025. The following was documented:
"Suspension was marked. LPN B had a hire date of 5/23/2025.
-Unprofessional behavior in the workplace as a LPN Manager-multiple staff, vendor and family complaints about oversharing sensitive, personal information; talking loudly in common area and being overly emotional with responses.
-Not meeting performance expectations and lack of professional judgement: Multiple staff complaints about not follow up on resident changes of status as noted in ECP and brought to

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	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL ST SUN PRAIRIE, WI 53590

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N 353	Continued From page 7	N 353		

LPN's attention while working.
-Multiple family complaints about lack of follow up through on care plan tasks:
-[Resident 2]-failure to contact POA when resident refuses medications-family contacting [Administrator A] for updates given lack of consistent communication.
-[Resident 3]-failure to contact POA weekly with recap of behaviors-family contacting [Administrator A] for updates given the lack of consistent communication.
-[Resident 4]-care conference with family regarding end of life planning and family complained about [LPN B's] inability to handle the conversation emotionally and professionally."

Surveyor reviewed the provider's policy on Change of Condition. The following was documented:
"Staff will provide health monitoring to ensure that changes in tenant/resident condition are identified and that prompt and adequate treatment is provided when changes occur.
Procedure:
Any staff that identifies a possible change of condition in physical or mental status of a tenant/resident will notify the Executive Director, Nurse or designee immediately.
Definition of significant change includes, but is not limited to:
-a noticeable change in mental awareness, attitude, cognizance, or consciousness;
The following steps will be taken if a change in condition is suspected:
a. Ensure tenant/resident safety.
b. Check vital signs and document.
c. Document tenant/resident complaints and symptoms.
1. Any staff that identifies a possible change of condition in physical or mental status of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL 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 353	Continued From page 8	N 353		

tenant/resident will notify the Executive Director, Nurse or designee immediately.
2. The Executive Director, Nurse or designee will immediately notify the tenant's practitioner, legal representative, family and case management agency of a significant change in the tenant s physical or mental condition.
3. Medical care and treatment will be initiated at the direction of the physician.
4. The Tenant/Resident record and service plan will be updated."

-Resident 1's record did not include evidence his/her legal representative and/or physician was notified of a change in behaviors from at least 07/09/2025 to 07/20/2025 (12 days), even though staff recorded Resident 1's observations and staff reported concerns to LPN B.

Interviews:

On 10/06/2025 at 9:40 AM, Surveyor interviewed Caregiver D. Caregiver D reported s/he started working at the facility in April 2025. Caregiver D reported Resident 1 was always a happy person and would eat 100% of his/her meals. Caregiver D reported over the summer, the provider employed LPN B and staff reported concerns to him/her about resident care. Caregiver D confirmed Resident 1 had a change of condition in July 2025 and s/he was not eating as much, going to his/her room, and his/her mood changed.

On 10/06/2025 at 10:08 AM, Surveyor interviewed Caregiver C. Caregiver C reported s/he had been working at the facility for over 4 years. Caregiver C reported Resident 1 was a happy person and was pretty independent with activities of daily living prior to his/her decliner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL ST SUN PRAIRIE, WI 53590

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N 353	Continued From page 9	N 353		

Caregiver C reported when Resident 1 started to decline in July 2025, s/he recalls, Resident 1 would come to dining room table and s/he could not remember how to use utensils or feed him/herself. Caregiver C reported Resident 1's mood changed a lot. Caregiver C reported s/he reported changes to LPN B, but s/he did not take our concerns seriously and noted it was his/her dementia.

On 10/06/2025 at 10:25 AM, Surveyor interviewed Administrator A regarding Resident 1's change of condition being reported to LPN B. Administrator A reported LPN B was employed at the provider from May to September and was terminated due to not following up with families about resident care. Administrator A noted LPN B did not have concerns associated with Resident 1 directly that s/he was aware of. Administrator A reported Resident 1 was usually happy, but in July 2025, s/he had a steep decline and after coming back from the hospital, s/he was placed on hospice and passed away in August.

On 10/06/2025 at 12:02 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Surveyor questioned the 7 entries staff recorded in Resident 1's record regarding a change in his/her behaviors and interviews conducted with staff. Administrator A acknowledged Resident 1 displayed behaviors s/he had never observed such as grabbing his/her head with his/her hands and isolating him/herself. Administrator A explained at the time, LPN B was in charge of following up on resident concerns and talking to family. Administrator A stated in July 2025, Resident 1's POA was in Canada, but was available via phone. Administrator A acknowledged Resident 1 had not been provided adequate treatment for a change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL 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 353	Continued From page 10 in his/her behaviors that s/he had been experiencing for at least 12 days until LPN B reported concerns on 07/21/2025. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 353		
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 the Individual Service Plan (ISP) was updated when there was a change in needs and physical or mental condition Resident 1. Resident 1's ISP was not updated to include his/her fall risk. Findings include:	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL ST SUN PRAIRIE, WI 53590

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N 389	Continued From page 11	N 389		

The provider is licensed to care up to 28 residents in the following client groups: terminally ill, irreversible dementia/Alzheimer's, physically disabled, and advanced age.

On 10/06/2025, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 08/31/2021 with diagnosis including Alzheimer's disease, seizures, and prediabetes. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 1's individual support plan (ISP) dated 08/07/2025 documented: "Resident has been identified as a fall risk." The ISP did not include interventions to mitigate Resident 1's fall risk.

Resident 1's incident reports documented:
"-06/16/2025: Unwitnessed fall: staff heard a commotion from resident's room slightly after dinner. Writer went to check on resident and found them on the floor on their hands and knees. Resident stated that they had lost balance and fell. Resident performed full ROM. Resident denied hitting head and denied any complaints of pain. Resident had no visible injuries.
-06/19/2025: Unwitnessed fall: resident was trying to sit down in chair in the dining room, the chair slid out from under [him/her] and [s/he] fell down. [S/he] did complain of hitting right knee, said there was pain, but unable to rate.
-07/21/2025: Unwitnessed fall: resident was found in common area in front of second row of chairs, half lounging on the floor. When asked what happened, resident was unable to remember how of why fall occurred. It appears that resident tripped on a wheelchair that was sitting in [his/her] path of walking. Resident denies any pain, injuries or hitting [his/her] head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017238	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYLAND CROSSINGS	1249 SCHOOL 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 389	Continued From page 12 Staff utilized gait belt and was able to get resident off floor and sitting in a chair. -07/25/2025: Witnessed fall: resident was walking to [his/her] toilet, [s/he] lost balance and fell. Resident hit [his/her] right side of [his/her] body and head on [his/her] bathroom shower floor. [S/he] was gasping for air. Writer did put a pillow underneath [his/her] head till EMS arrived. -07/31/2025: Unwitnessed fall: upon entering resident's room to show staff how to unclip residents new catheter bag, writer found resident on the floor by [his/her] bed with blood all over [his/her] face, hands, and legs along with the floor. Resident has laceration to above right eye. -08/03/2025: Unwitnessed fall: staff walking into resident's room to check on [him/her] and [s/he] was found on the floor. Resident stated that [s/he] needed to have a bowel movement and got up and fell onto the ground." On 10/06/2025 at 12:02 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Surveyor shared that Resident 1's record included 6 falls between June-August 2025 and Resident 1's ISP did not include any interventions for staff to use to mitigate Resident 1's fall risk. Administrator A reported LPN B oversaw updating resident care plans at that time. Administrator A acknowledged Resident 1's ISP did not include interventions for staff to utilize in mitigating his/her fall risk. Cross Reference: N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment	N 389		