STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018270	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN CROSSING AT MARITIME GARDENS	1945 DEWEY STREET MANITOWOC, WI 54220

(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 07/22/2025, with information gathered through 07/23/2025, Surveyor conducted one (1) complaint investigation and 1 facility self report review at Sylvan Crossings at Maritime Gardens in Manitowoc. One of 1 complaint was substantiated. As a result of the survey, 1 deficiency will be issued. Census: 18	N 000		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 (Resident 1) resident reviewed were free from sexual abuse. Resident 1 was sexually assaulted by Resident 2. Findings Include: On 06/23/2025, the department received an "Assisted Living Facility Self-Report." The report	N 348		

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

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N 348	Continued From page 1 indicated on 06/22/2025, "[Director of Compliance, Training and Education A] was contacted at 4:37 AM by [Caregiver E] to report that while making their 4 AM rounds with [Caregiver C], [Resident 2] was found in [Resident 1's] room sexually assaulting [him/her]. [Director of Compliance, Training and Education A] instructed [Caregiver E] to separate the residents. Staff members were instructed to contact local law enforcement to complete an investigation. Local law enforcement met with both residents. They had enough evidence to arrest [Resident 2]. Family members to both families were contacted. [Resident 1] was sent to the hospital for further evaluation. [Resident 2] was taken into custody and not returning to the facility. APS [Adult Protective Services] was contacted and made aware of the situation." On 07/03/2025, the department received a complaint regarding abuse allegations. On 07/22/2025, Surveyor conducted an onsite visit to the facility. At 9:30 AM, Surveyor interviewed Director of Compliance, Training and Education A. S/he indicated at the time of the incident on 06/22/2025 s/he was the interim director. Since then, they have hired a new director who is currently being trained. Director of Compliance, Training and Education A stated s/he received a call around 4:30/5:00 AM on 06/22/2025 from the 3rd shift caregivers stating they found Resident 2 in Resident 1's room engaging in a sexual act. S/he told staff to separate the residents and then proceeded to call other management staff to respond to the facility to start an investigation as s/he was out of town. Director of Compliance, Training and Education A stated caregivers called the police and they responded to the facility and spoke with staff and	N 348		

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N 348	Continued From page 2	N 348		

both residents involved. Police had indicated Resident 2 admitted to sexually assaulting Resident 1. Police arrested Resident 2 and was taken away. Resident 1's family was notified of the incident and agreed to have Resident 1 sent to the hospital for a SANE (Sexual Assault Nurse Examiner) exam. Resident 1's family did want to press charges against Resident 2. Director of Compliance, Training and Education A verified Resident 2 is no longer residing at the facility. Surveyor requested Resident 1 and Resident 2's resident records.

Resident 1 was admitted to the facility on 12/05/2024 with diagnoses to include supranuclear palsy (neurodegenerative disease involving the gradual deterioration and death of specific volumes of the brain), depression, and mild cognitive impairment. Resident 1's most recent ISP (Individualized Service Plan) with a print date of 07/22/2025, indicated Resident 1 has an activated health care power of attorney, requires full assistance from staff with all activities of daily living, uses a wheelchair for mobility and requires staff to assist with pushing the wheelchair, and requires the use of a 2 person mechanical lift for all transfers.

Resident 2 was admitted to the facility on 08/27/2024 with diagnoses to include Alzheimer's disease, mild cognitive impairment, and a communicable disease. Resident 2's most recent ISP with a print date of 07/22/2025, indicated Resident 2 has an activated health care power of attorney, and is independent with ambulation and transfers.

On 07/22/2025 at 10:00 AM, Surveyor interviewed Activity Coordinator D. Activity Coordinator D stated s/he received a call around

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N 348	Continued From page 3 4:30 AM from Caregiver C. Caregiver C told Activity Coordinator D that Resident 2 was found in Resident 1's room performing a sexual act on Resident 1. Caregiver C asked Activity Coordinator D to come to the facility to help. Activity Coordinator D stated s/he immediately drove to the facility (only lives about 2 blocks away). Activity Coordinator D stated when s/he arrived at the facility, Resident 2 was in the living room and asked Activity Coordinator D what time his/her friend was coming to pick him/her up for church. Activity Coordinator D indicated there was nothing out of the ordinary with Resident 2. Activity Coordinator D stated Resident 1 was still in his/her room with another caregiver. Police arrived shortly after Activity Coordinator D and police interviewed Resident 1 and Resident 2 and requested Activity Coordinator D's assistance with the interviews. Activity Coordinator D indicated Resident 1 answered questions with a yes/no which is typical for Resident 1 due to his/her diagnoses. Resident 1 was able to recall someone was in his/her room that morning but was not able to identify that it was Resident 2. In addition, when Resident 1 was asked if anyone touched him/her, Resident 1 was able to push his/her blankets down and pointed to genital area. Activity Coordinator D indicated Resident 1 didn't seem upset or angry but that due to Resident 1's diagnoses, Resident 1 doesn't display many emotions. Activity Coordinator D indicated during the police interview with Resident 2, Resident 2 admitted to performing a sexual act with Resident 1 but that Resident 2 had indicated Resident 1 was his/her boy/girlfriend and they met at church and Resident 1 lived next to him/her. Activity Coordinator D stated Resident 1 and 2 did not meet at church and did not live next to each other. Activity Coordinator D stated after speaking with staff, family members and	N 348		

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N 348	Continued From page 4	N 348		

residents, police arrested Resident 2. Activity Coordinator D stated s/he walked out of the facility with Resident 2 and police to the police car where Resident 2 was handcuffed and taken to jail.

On 07/22/2025 at 10:20 AM, Surveyor interviewed Caregiver C. Caregiver C stated s/he usually works the first shift but on 06/22/2025, s/he was working the night shift (11pm-7am). Caregiver C stated s/he was conducting 2 hour checks throughout the night on all the residents. Caregiver C stated they had done checks on Residents 1 and 2 at 12am, 2am, 3am and then during the 4am rounds is when Caregiver C opened the door to Resident 1's room and saw Resident 2 kneeling beside Resident 1's bed performing a sexual act. Caregiver C stated s/he was "distraught" and told Resident 2 s/he did not belong in this room and what s/he was doing was not ok. Caregiver C stated Resident 2 said, "You [guys/gals] don't belong in here." Caregiver C stated Caregiver E assisted in removing Resident 2 from Resident 1's room. Caregiver C stated s/he noticed Resident 1's brief was wet and down at his/her ankles while s/he laid in bed. Caregiver C stated it appeared Resident 1 was not awake and felt Resident 1 did not provide consent to participating in the sexual act. Caregiver C stated s/he was involved with the police interview of Resident 1. During the police interview, Caregiver C stated Resident 1 was able to recall that someone touched him/her but did not recall the name of the person. Caregiver C verified Resident 1 uses a broda wheelchair and hoyer lift for transfers and requires full staff assistance for activities of daily living. Caregiver C verified Resident 2 is ambulatory and independent with all tasks.

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N 348	Continued From page 5 On 07/22/2025 at 10:45 AM, Surveyor interviewed Director B. Director B stated s/he is the director of a sister facility but was the responding director on 06/22/2025, the day of the incident. Director B stated s/he did receive a call from Director of Compliance, Training and Education A around 5:30/6am regarding a possible sexual assault and asking if Director B could respond to the facility to help staff. Director B stated when s/he arrived at the facility Resident 2 was already gone with the police. Director B indicated s/he was waiting for Resident 1's family member to arrive/call to give approval for Resident 1 to be sent to the hospital for the SANE exam. Resident 1's family member eventually called and gave permission for exam. Ambulance was called to transport Resident 1 and Director B left when ambulance and police left to take Resident 1 to the hospital. Director B stated, this was a "surprise to everyone." On 07/22/2025 at approximately 11:00 AM, Surveyor attempted to interview Resident 1. Resident 1 was observed sitting in his/her room in recliner with blanket over him/her. Resident 1 responded "yes" when Surveyor asked if s/he was doing good today. Resident 1 was not able to provide many other details due to his/her limited ability to speak. Surveyor did not identify any concerns with Resident 1's physical appearance or mood. In summary, on 06/22/2025, Resident 2 was found in Resident 1's room performing a sexual act with Resident 1. Police were called and an investigation was conducted. Resident 2 admitted to police s/he performed a sexual act with Resident 1. Police arrested Resident 2. Resident 2 is no longer residing at the facility.	N 348		