| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0010729 | A. BUILDING: _____ B. WING _____ | C 05/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SYLVAN CROSSINGS IN WESTSHIRE VILLAGE | 5475 WESTSHIRE CIRCLE WAUNAKEE, WI 53597 |

| (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 |
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| N 000 | Initial Comments<br><br>On 05/27/2026, Surveyor conducted a complaint investigation and self-report investigation at Sylvan Crossings in Westshire Village.<br><br>Four (4) deficiencies were identified. The complaint was substantiated.<br><br>Census: 30 | N 000 | | |
| N 164 | 83.12(4)(b) Reporting when law enforcement is called.<br><br>A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not send a written report to the department within 3 working days after law enforcement personnel were called to the CBRF as a result of Resident 1's aggressive behavior on 03/09/2026.<br><br>Findings include:<br><br>On 05/27/2026, Surveyor conducted a complaint investigation and self-report investigation. Surveyor reviewed the closed record of Resident 1. Resident 1 was admitted to the facility on 01/09/2026 with diagnosis including dementia. | N 164 | | |

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

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| N 164 | Continued From page 1<br><br>Surveyor reviewed Resident 1's progress notes. On 03/09/2026, the progress notes documented, "The resident left [his/her] room at 2:15 and went to room 24 and assaulted the resident by slapping [him/her]. When I saw that [s/he] left [his/her] room and saw [him/her] going into room 24, I ran, but when I entered I saw that [s/he] hit the resident and I told [him/her] to stop, and [s/he] sat on the resident's bed. I told [him/her] to leave and [s/he] didn't listen. When I told [him/her] again to leave, [s/he] stood up and tried to hit us, and I had to call the police."<br><br>Surveyor reviewed the provider's electronic file and did not see that the provider had reported to the department after law enforcement personnel were called to the facility on 03/09/2026.<br><br>On 05/27/2026 at 11:53 a.m., Administrator B spoke with Compliance A and confirmed that the provider did not report that law enforcement was called to the facility on 03/09/2026. | N 164 | | |
| N 169 | 83.12(5)(a) Notification: incident, injury, changes.<br><br>The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. | N 169 | | |

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| N 169 | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not immediately notify Resident 1's legal representative and his/her physician after an incident on 04/10/2026 when several bruises were found on Resident 1's body or the change in Resident 1's physical condition after unintentionally losing 30 pounds in 10 weeks.<br><br>Findings include:<br><br>On 05/27/2026, Surveyor conducted a complaint investigation and self-report investigation. The provider is licensed as a class CNA (Non-ambulatory) CBRF able to serve up to 34 residents within the client groups of irreversible dementia/Alzheimer's, advanced age, and physically disabled.<br><br>Surveyor reviewed the closed record of Resident 1. Resident 1 was admitted to the facility on 01/09/2026 with diagnosis including dementia.<br><br>Surveyor reviewed Resident 1's progress notes, which documented:<br>-04/10/2026, "When I went to giver [Resident 1 his/her] medication, I noticed [s/he] was a little anxious. I gave [him/her] lorazepam, and [s/he] asked for help to take a bath. When I undressed [him/her], I noticed [s/he] had several bruises on [his/her] body, including a larger one on [his/her] back. I notified the managers about what I had seen. [S/he] was left clean and laying down in [his/her] room."<br>There was no documentation in Resident 1's record that documented the extent/details of the bruising, investigation into the cause of the bruising, or that Resident 1's legal representative or physician was notified. | N 169 | | |

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| N 169 | Continued From page 3<br><br>Surveyor reviewed a hospital discharge summary from Resident 1's hospitalization from 04/12/2026 to 04/21/2026. Upon admission, Resident 1 was diagnosed with malnutrition, closed fracture of left rib, and a hematoma. The hospital assessment documented that Resident 1, "Had unwitnessed fall at facility. Has multiple bruises at different stages as well as hematoma on [his/her] forehead."<br><br>Surveyor reviewed Resident 1's vital history that documented Resident 1's weight on 01/29/2026 was 208 pounds. The hospital documented Resident 1's weight was 178 on 04/12/2026, indicating a pound weight loss in 73 days.<br><br>On 05/27/2026 at 11:53 a.m., Administrator B confirmed that Resident 1's legal representative and physician were not made aware of the incident resulting in multiple bruises discovered on 04/10/2026 or his/her refusal of meals. Compliance A stated s/he does not know why it was not reported to Resident 1's legal representative and physician. | N 169 | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>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 | N 389 | | |

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| N 389 | Continued From page 4<br>involvement in, understanding of and agreement with the individual service plan.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not update the individual service plan (ISP) annually or when there was a change in resident's needs, abilities or physical or mental condition.<br><br>Resident 1's ISP was not updated to include incontinence and meal consumption.<br>Resident 2's ISP was not updated to include elopement, alcohol dependence, or his/her suicidal ideation.<br><br>This is a repeat deficiency from statement of deficiency (SOD) PG8311, dated 01/31/2023.<br><br>Findings include:<br><br>On 05/27/2026, Surveyor conducted a complaint investigation and self-report investigation. The provider is licensed as a class CNA (Non-ambulatory) CBRF able to serve up to 34 residents within the client groups of irreversible dementia/Alzheimer's, advanced age, and physically disabled.<br><br>Example 1: Resident 1<br><br>Surveyor reviewed the closed record of Resident 1. Resident 1 was admitted to the facility on 01/09/2026 with diagnosis including dementia.<br><br>Surveyor reviewed Resident 1's progress notes, which documented:<br>-01/12/2026, offered lunch but ate about 25% | N 389 | | |

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| N 389 | Continued From page 5 | N 389 | | |

-01/13/2026, hasn't wanted to eat anything all day
-01/27/2026, did not want to eat anything
-02/01/2026, "Resident was awake in living room at start of shift and it was obvious that [s/he] was incontinent of BM. It had leaked thru onto the furniture and up the back of [his/her] shirt. ...While showering [s/he] had another BM."
-02/05/2026, "[S/he] had an incontinence accident before team members got here, but was not allowing anybody to help [him/her] change. After a while, team members were trying ton convince [him/her] to get changed and [s/he] then put [his/her] hand down [his/her] pants and it got covered with BM."
-02/09/2026, "[S/he] is not eating; instead, [s/he] is discarding [his/her] food, ,utensils, and cups."
-02/10/2026, "[Resident 1] was found in another resident's room asleep in their bed. [S/he] had a bowel movement all over the bathroom. Was wanting to sit in [his/her] chair in soiled clothing and refusing to leave room..."
-02/13/2026, "Resident stayed in bed all day but woke for scheduled medication. Writer unsure if [s/he] ate any of the food from the meal trays either."
-02/16/2026, "Writer was told by care staff that [s/he] did not sleep all night and refused to leave the theatre at all and would[n't] let care staff help [him/her] at all and so [s/he] urinated all over the hallway a few times it looks like due to the amount of urine."
-02/16/2026, "[Resident 1] has been sitting in the theatre room all mooring, has not touched [his/her] breakfast but it is sitting beside [him/her] on the table..."
-02/18/2026, "[S/he] refused to change clothes, didn't eat, and spent the whole afternoon hitting [his/her] head."
-02/19/2026, "[Resident 1] didn't' eat and hits [him/herself] harder on the head with [his/her]

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| N 389 | Continued From page 6<br>hands every day.<br>-02/20/2026, refused breakfast<br>-02/23/2026, "[Resident 1] threw [his/her] food in the toilet at dinner time."<br>-02/24/2026, "We had to change [him/her] between three people because [s/he] was all dirty and wouldn't let us change [him/her] to the point that [s/he] was very aggressive, [s/he] didn't want to eat and threw all the food in the bathroom. "<br>-03/01/2026, "[S/he] threw [his/her] breakfast tray on the floor with all the food, refused [his/her] pills on two occasions, but finally took them."<br>-03/01/2026, "[S/he] was very restless all afternoon, did not eat, and threw the food on the floor, peed in the home theatre, and did not want to enter [his/her] room when [s/he] wanted to change it."<br>-03/08/2026, "[S/he] did however toss [his/her] breakfast try on the floor."<br>-03/22/2026, "Resident has been staying in [his/her] room for most of the day time hours most days, and when brought meals, [s/he] throws everything on the floor. Writer is concerned that [s/he] is not eating or drinking much..."<br>-03/29/2026, "[S/he] hasn't' left [his/her] room all afternoon and every time food is brought to [him/her], [s/he] throws it on the floor. [S/he] didn't eat dinner either, and the times water or snack is brought to [him/her], [s/he] throws it on the ground."<br>-04/01/2026, "[Resident 1] did not have dinner..."<br>-04/04/2026, "[S/he] didn't want to eat..."<br>-04/06/2026, "...ate about 50% of [his/her] breakfast with assistance."<br>-04/06/2026, "[Resident 1] did not have dinner."<br>-04/07/2026, "[S/he] stayed in [his/her] room all afternoon without going out, [s/he] ate well but at mealtime [s/he] refused it and did not want to drink it." | N 389 | | |

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| N 389 | Continued From page 7<br><br>Surveyor reviewed the individualized service plan (ISP) of Resident 1. The ISP, dated 01/09/2026, documented that Resident 1 requires stand by assistance and occasional cueing throughout meals and wishes to complete meals independently while receiving support as needed. The ISP documented that Resident 1 chooses to eat meals in his/her room and wishes to maintain independence and comfort while dining in the preferred location. Under toileting/incontinence, the ISP documented that Resident 1 requires monitoring of bowel movements to maintain comfort, prevent complications, and support overall health and well-being. That Resident 1 requires physical assistance from two caregivers for toileting and wishes to complete toileting safety and comfortable with this level of support.<br><br>Resident 1's ISP did not include Resident 1's refusals of meals or approaches for how staff should assist him/her with eating. The ISP did not include Resident 1's increase in being incontinent in public areas or refusals to get cleaned up after or approaches for caregivers to try to redirect the behavior.<br><br>On 05/27/2026 at approximately 12:30 p.m., Administrator B confirmed that Resident 1's ISP had not been updated.<br><br>Example 2: Resident 2<br><br>On 05/09/2026, the department received a self-report documenting that Resident 2 went to Walgreens and had not returned.<br><br>On 05/27/2026, Surveyor reviewed the record of Resident 2. Resident 2 was admitted to the facility on 02/07/2025 with diagnoses including alcohol | N 389 | | |

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| N 389 | Continued From page 8<br>use, cocaine abuse, opioid dependence, and depression.<br><br>Surveyor reviewed a hospital discharge summary that documented that on 05/15/2026 at 11:54 p.m., Resident 2 went to the hospital. "[S/he] reports feeling about things recently which caused [him/her] to return to drinking. [S/he] left [his/her] assisted living facility about 1 week ago due to [his/her] depressed mood and desire to drink, has been living on the street for the past week. Has not taken any medications for the last week since [his/her] AFL (assisted living facility) managed [his/her] meds. Has been having 5-6 wine coolers per day. States [s/he] was free of alcohol for years before relapsing last week. Last had something to eat about 1 week ago. Has hx (history) of seizures due to alcohol withdrawal. ...Upon arrival patient had stated that [s/he] wanted 'to walk into traffic' but had not taken any measures to carry out this plan and recognized need for medical attention." Resident 2 was hospitalized from 05/15/2026 to 05/19/2026.<br><br>Surveyor reviewed Resident 2's ISP, dated 03/02/2026. The ISP did not include Resident 2's alcohol dependence, elopement, or suicidal ideation and did not include measured goals and approaches to redirect him/her.<br><br>On 05/27/2026 at 12:45 a.m., Compliance A confirmed that Resident 2's ISP had not been updated since s/he returned to the facility and stated s/he does not know why it had not been updated. | N 389 | | |
| N 431 | 83.38(1)(g) Health monitoring.<br><br>As appropriate, the CBRF shall teach residents | N 431 | | |

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| N 431 | Continued From page 9<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not provide or arrange services adequate to meet the needs of Resident 1. The provider did not observe Resident 1's food intake and acceptance of diet and did not report significant deviations from normal food intake patterns to Resident 1's physician.<br><br>This is a repeat deficiency from statement of deficiency (SOD) PG8311, dated 01/31/2023. | N 431 | | |

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| N 431 | Continued From page 10<br>Findings include:<br><br>On 05/27/2026, Surveyor conducted a complaint investigation and self-report investigation. The provider is licensed as a class CNA (Non-ambulatory) CBRF able to serve up to 34 residents within the client groups of irreversible dementia/Alzheimer's, advanced age, and physically disabled.<br><br>Surveyor reviewed the closed record of Resident 1. Resident 1 was admitted to the facility on 01/09/2026 with diagnosis including dementia.<br><br>Surveyor reviewed Resident 1's progress notes, which documented:<br>-01/12/2026, offered lunch but ate about 25%<br>-01/13/2026, hasn't wanted to eat anything all day<br>-01/27/2026, did not want to eat anything<br>-02/09/2026, "[S/he] is not eating; instead, [s/he] is discarding [his/her] food, ,utensils, and cups."<br>-02/13/2026, "Resident stayed in bed all day but woke for scheduled medication. Writer unsure if [s/he] ate any of the food from the meal trays either."<br>-02/16/2026, "[Resident 1] has been sitting in the theatre room all mooring, has not touched [his/her] breakfast but it is sitting beside [him/her] on the table..."<br>-02/18/2026, "[S/he] refused to change clothes, didn't eat, and spent the whole afternoon hitting [his/her] head."<br>-02/19/2026, "[Resident 1] didn't eat and hits [him/herself] harder on the head with [his/her] hands every day.<br>-02/20/2026, refused breakfast<br>-02/23/2026, "[Resident 1] threw [his/her] food in the toilet at dinner time."<br>-02/24/2026, "We had to change [him/her] between three people because [s/he] was all dirty | N 431 | | |

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| N 431 | Continued From page 11 | N 431 | | |

and wouldn't let us change [him/her] to the point that [s/he] was very aggressive, [s/he] didn't want to eat and threw all the food in the bathroom. "
-03/01/2026, "[S/he] threw [his/her] breakfast tray on the floor with all the food, refused [his/her] pills on two occasions, but finally took them."
-03/01/2026, "[S/he] was very restless all afternoon, did not eat, and threw the food on the floor, peed in the home theatre, and did not want to enter [his/her] room when [s/he] wanted to change it."
-03/08/2026, "[S/he] did however toss [his/her] breakfast try on the floor."
-03/22/2026, "Resident has been staying in [his/her] room for most of the day time hours most days, and when brought meals, [s/he] throws everything on the floor. Writer is concerned that [s/he] is not eating or drinking much..."
-03/29/2026, "[S/he] hasn't' left [his/her] room all afternoon and every time food is brought to [him/her], [s/he] throws it on the floor. [S/he] didn't eat dinner either, and the times water or snack is brought to [him/her], [s/he] throws it on the ground."
-04/01/2026, "[Resident 1] did not have dinner..."
-04/04/2026, "[S/he] didn't want to eat..."
-04/06/2026, "...ate about 50% of [his/her] breakfast with assistance."
-04/06/2026, "[Resident 1] did not have dinner."
-04/07/2026, "[S/he] stayed in [his/her] room all afternoon without going out, [s/he] ate well but at mealtime [s/he] refused it and did not want to drink it."

Surveyor reviewed the individualized service plan (ISP) of Resident 1. The ISP, dated 01/09/2026, documented that Resident 1 requires stand by assistance and occasional cueing throughout meals and wishes to complete meals

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0010729 | A. BUILDING: _____ B. WING _____ | C 05/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYLVAN CROSSINGS IN WESTSHIRE VILLAGE | 5475 WESTSHIRE CIRCLE WAUNAKEE, WI 53597 |

| (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 12 | N 431 | | |

independently while receiving support as needed. The ISP documented that Resident 1 chooses to eat meals in his/her room and wishes to maintain independence and comfort while dining in the preferred location.

Surveyor reviewed Resident 1's vital history that documented Resident 1's weight on 01/29/2026 was 208 pounds. There was no documentation of any other weight monitoring.

Surveyor reviewed a hospital discharge summary from Resident 1's hospitalization from 04/12/2026 to 04/21/2026. Upon admission, Resident 1 was diagnosed with malnutrition with his/her weight documented as 178 pounds.

On 05/27/2026, at 11:53 a.m., Administrator B stated that the provider had not been documenting Resident 1's food intake. Administrator B stated s/he was unaware of Resident 1's 30 pound weight loss in 73 days and that the provider had not been monitoring his/her weight.

On 05/27/2026 at approximately 12:45 p.m., Compliance A stated s/he does not know why the provider was not documenting Resident 1's food intake or monitoring his/her unintentional weight loss.