STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110524	A. BUILDING: _____ B. WING _____	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN CROSSINGS OF FITCHBURG	5784 CHAPEL VALLEY RD FITCHBURG, WI 53711

(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 08/22/2023, with information gathered through 08/29/2023, Surveyor conducted a complaint investigation at Sylvan Crossings of Fitchburg, a CBRF in Fitchburg. Two deficiencies were identified. One deficiency is a repeat deficiency - See Statement of Deficiency (SOD) LBS211, dated 12/23/2020 and KFI311, dated 01/19/2023. The complaint was substantiated. Census: 18	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 interview and record review, the provider did not ensure Resident 1 received prompt and adequate treatment following a fall during the overnight of 08/13/2023 to 08/14/2023. This is a repeat deficiency. See Statement of Deficiency (SOD) LBS211, dated 12/23/2020 and KFI311, dated 01/19/2023. Findings include: On 08/22/2023, Surveyor conducted a complaint investigation alleging that a resident fell and did not receive assistance for hours.	N 353		

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

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N 353	Continued From page 1 On 08/22/2023 at approximately 8:00 a.m., Surveyor reviewed a paramedic report, dated 08/14/2023. The report documented that paramedics were called to the facility on 08/14/2023 at 8:20 a.m. for Resident 1, who had fallen. Resident 1 was found on the ground lying next to his/her bed. Resident 1 was observed with bruising, skin tears and a bandage on his/her right forearm. The report stated Resident 1 told paramedics s/he had gotten out of bed around 10:00 p.m. to get water or go to the bathroom and had been yelling for help for "hours" after sustaining a fall. On 08/22/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 04/28/2023. Resident 1's individual service plan (ISP), dated 07/14/2023, documented s/he required every 2 hour wellness checks. Resident 1's record included an incident report, dated 08/14/2023, that stated Resident 1 fell, reportedly when s/he was trying to get back into bed after using the bathroom. The report stated, " ...Resident had bruising from [right] clavicle all down [his/her] arm to [his/her] elbow and skin tear and bruising to [his/her] right wrist. [S/he] had bruising on [his/her] left forearm. [S/he] had a bruise on [his/her] right cheek also complains of neck pain ..." The incident report did not document the last time Resident 1 had been checked on by caregivers. Resident 1's record included a hospital discharge summary, dated 08/17/2023, which stated Resident 1 was diagnosed with a right proximal humerus fracture and community acquired pneumonia. On 08/22/2023 at approximately 12:30 p.m., Surveyor interviewed Director A. Director A stated	N 353		

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N 353	Continued From page 2 Resident 1 was found down in his/her room shortly after Director A had arrived to work on 08/14/2023. Director A stated s/he was unsure when the fall occurred. On 08/22/2023 at approximately 12:50 p.m., Surveyor interviewed Caregiver B. Caregiver B stated s/he worked the night shift from 08/13/2023 to 08/14/2023, but didn't care for Resident 1 that evening. Caregiver B stated Resident 1 was independent, so caregivers were supposed to knock on his/her door during rounds, but that Resident 1 liked to keep his/her door shut. Caregiver B stated s/he had heard that Resident 1 allegedly fell at 10:00 p.m., but that's all s/he had heard. On 08/22/2023 at approximately 3:00 p.m., Surveyor interviewed Former Caregiver C. Former Caregiver C stated s/he worked the night shift from 08/13/2023 to 08/14/2023. Former Caregiver C stated s/he did not complete rounds on Resident 1 because Resident 1 was "pretty much independent." Former Caregiver C stated s/he wasn't instructed to round on all the residents until after Resident 1's fall because the former administrator had instructed staff they only needed to assist Resident 1 with medications. Surveyor asked Former Caregiver C rounded with morning caregivers at shift change. Former Caregiver C replied, "No." On 08/29/2023 at approximately 8:00 a.m., Surveyor interviewed Paramedic D. Paramedic D stated s/he responded to the provider's facility on 08/14/2023. Paramedic D stated Resident 1 answered all questions appropriately, knew the date and knew where s/he was. Paramedic D stated Resident 1 stated s/he had been calling for help for hours. Paramedic D stated Resident 1	N 353		

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N 353	Continued From page 3 had several skin tears that had dry blood and his/her right shoulder to the arm was "completely black and blue", which in Paramedic D's experience would take hours to form. Summary: Resident 1 sustained a fall during the overnight hours of 08/13/2023 to 08/14/2023. Caregivers did not complete wellness checks on Resident 1 overnight because they believed s/he was "independent." Resident 1 was found by AM staff with several skin tears and bruising to his/her right shoulder and upper extremity. Resident 1 was sent to the hospital and diagnosed with a right proximal humerus fracture.	N 353		
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	N 431		

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N 431	Continued From page 4 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 changes in Resident 1's health was documented in his/her record. Findings include: On 08/22/2023 at approximately 8:00 a.m., Surveyor reviewed a paramedic report, dated 08/14/2023. The report documented that paramedics were called to the facility on 08/14/2023 at 8:20 a.m. for Resident 1, who had fallen. Resident 1 was found on the ground laying next to his/her bed. Resident 1 was observed with bruising, skin tears and a bandage on his/her right forearm. The report stated Director A was present and did not have any documentation of a wound to Resident 1's right forearm prior to the fall. On 08/22/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 004/28/2023. Resident 1's record included an incident report, dated 08/14/2023, that stated Resident 1 fell, reportedly when s/he was trying to	N 431		

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N 431	Continued From page 5 get back into bed after using the bathroom. The report stated, " ...Resident had bruising from [right] clavicle all down [his/her] arm to [his/her] elbow and skin tear and bruising to [his/her] right wrist. [S/he] had bruising on [his/her] left forearm. [S/he] had a bruise on [his/her] right cheek also complains of neck pain ...". The report did not reference Resident 1's bandage to his/her right arm. On 08/22/2023 at approximately 12:30 p.m., Surveyor interviewed Director A. Director A stated Resident 1 was found down in his/her room shortly after Director A had arrived to work on 08/14/2023. Director A stated s/he recalled seeing a "fishnet" like bandage on Resident 1's right forearm, but wasn't sure what it was from. Director A stated s/he wasn't sure if Resident 1 had a prior wound or if s/he had a recent lab draw. On 08/22/2023 at approximately 12:50 p.m., Surveyor interviewed Caregiver B. Caregiver B stated s/he recalled the wound and bandage to Resident 1's right forearm. Caregiver B stated the wound was observed on Resident 1's right forearm 2 days prior to his/her fall and Resident 1 had reported bumping his/her arm on the wall. Caregiver B stated s/he had placed the bandage on Resident 1's right forearm. Surveyor asked Caregiver B if s/he documented the wound or notified anyone of Resident 1's wound. Caregiver B replied, "No. I just addressed it." Director A was present for Surveyor's interview with Caregiver B and stated since Resident 1's fall the facility had completed education with caregivers regarding incident reporting. Resident 1 sustained a wound that was not documented in his/her record.	N 431		

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