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SYLVAN CROSSINGS OF FITCHBURG	5784 CHAPEL VALLEY RD FITCHBURG, WI 53711

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{N 000}	Initial Comments On 10/18/2022, Surveyors conducted a verification visit, standard survey and complaint investigation at Sylvan Crossings of Fitchburg. Eight deficiencies were identified. Two of the 8 deficiencies is a repeat violation from Statement of Deficiency #LBS211 dated 12/23/2020 and NKN513 dated 01/02/2020. The complaint was substantiated. Under statutory provisions of Wis.Stat. ch. 50 a $200 revisit fee is being assessed. Census: 14	{N 000}		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and staff interview, Caregiver E did not receive at least 15 hours per calendar year of continuing education in 2021.	N 277		

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

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N 277	Continued From page 1 Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: Standard precautions; prevention and reporting of abuse, neglect and misappropriation; fire safety and emergency procedures, including first aid. Findings include: On 10/18/2022 at approximately 9:20 AM, Surveyor asked Executive Director B (ED-B) and Operations Coordinator D to provide the staff file for Caregiver E. Caregiver E was hired on 06/05/2018. Surveyor asked Operations Coordinator D for the continued education for 2021. Operations Coordinator D provided documentation for training in dementia; rights; end of life and aggressive behavior. Surveyor asked about the duration of the training and if there was any training received in standard precautions, reporting of abuse, neglect and misappropriation; fire safety and emergency procedures, including first aid for 2021. Operations Coordinator D stated they had no idea about the duration and stated the employee records were not organized and they had to recreate all records. Operations Coordinator D stated s/he was aware of the regulatory requirement and understood that Caregiver E did not have the 15 hours of continued education for 2021 per said requirement.	N 277		
N 427	83.38(1)(c) Leisure time activities. 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	N 427		

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arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.

This Rule is not met as evidenced by:
Based on observations and staff interview the provider did not provide or arrange a daily activity program to meet the interests and capabilities of the residents. The staff did not encourage and promote participation in the activity program.

This is a repeat violation from Statement of Deficiency #LBS211 dated 12/23/2020.

Findings include:

Sylvan Crossing Fitchburg has a capacity for 19 adults and serves irreversible dementia/Alzheimer's and advanced aged.

On 10/18/2022, Surveyors toured the facility. Posted in the facility, Surveyor observed the October 2022 activity calendar. The following activities were listed for 10/18/2022:
10 AM- Gentle Movement
11 AM- Resident Council Meeting
2 PM- Arts/Crafts
3 PM- Snack and Chat
7 PM- Movie

At 10 AM, no activities were observed. The television was on in the main living area, located

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at the front of the facility. Two residents were seated in the living area.

At 11 AM, Surveyor observed Caregiver C in the hallway with a resident. Caregiver C was assisting the resident with ambulation. Several residents were observed in their rooms. Caregiver C was then observed assisting other residents with needs.

No resident council meeting was observed at 11:00 AM.

Surveyor interviewed Resident 6 on 10/18/2022, at 10:53 AM. Surveyor asked Resident 6 about activities. Resident 6 stated they do not have any activities as of maybe a few months ago. Resident 6 stated s/he used to enjoy the programs but there is nothing offered now and Resident 6 misses activities.

Surveyor interviewed Resident 9 on 10/18/2022, at 11:08 AM. Resident 9 stated they used to have activities but approximately one month ago the activity director stopped working at the facility. Resident 9 stated there are games in a closet people can play but nobody organizes anything. Resident 9 stated there is nothing to do.

Surveyor interviewed Resident 8 on 10/18/2022, at 11:14 AM. Resident 8 stated there is nothing to do and there are no activities any longer.

Surveyor interviewed Resident 3 on 10/18/2022, at 12:00 noon. Resident 3 stated the activity director left one month ago and how there is nothing to do.

At 2:00 PM, Surveyor did not observe Arts and Crafts as scheduled.

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N 427	Continued From page 4 On 10/18/2022, at 2:30 PM, Surveyor interviewed Executive Director B and Operations Coordinator D regarding activities. Operations Coordinator D and Executive Director B stated that the activity director did leave and has not been replaced as of 10/18/2022.	N 427		
N 434	83.38(1)(j) Information and referral. 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: Information and referral. The CBRF shall provide information and referral to appropriate community services. This Rule is not met as evidenced by: Based on record review and interviews, the CBRF did not provide information and referral to appropriate community services and inform emergency medical services (EMS) of Resident 10's health needs when Resident 10 suddenly became ill, required emergency medical services and needed to be transported to the hospital. Findings include: Sylvan Crossing Fitchburg has a capacity for 19 adults and serves irreversible dementia/Alzheimer's and advanced aged. On 10/18/2022, the department investigated a	N 434		

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complaint related to Resident 10's needs.

Surveyor review of Resident 10's record noted Resident 10's power of attorney was activated and Resident 10's diagnoses included Alzheimer's.

On 10/18/2022, Surveyor interviewed Executive Director B. Surveyor asked Executive Director B (ED-B) if ED -B recalled the events on 09/17/2022.

Surveyor asked Executive Director B who was working with Resident 10 when the incident occurred. Executive Director B stated Caregiver C, Caregiver F and Medication Passer G. Surveyor asked Executive Director B and Operations Coordinator D about the events on 09/17/2022. Executive Director B and Operations Coordinator D stated they were not in the building at the time and really did not know exactly what had happened but that the code to the office was provided to Medication Passer G so that medical information could be located. Executive Director B stated Medication Passer G was going between the laundry room and office and resident room at the time of the incident and Caregivers C and Caregiver F were very concerned about Resident 10 but believed the matter was being taken care of by Medication Passer G.

On 10/18/2022, at 11:20 AM, Surveyor interviewed Caregiver C. Caregiver C stated Caregiver C and Caregiver F assisted Resident 10 out of the bed, walked Resident 10 to the bathroom, turned on the shower as they prepared to give Resident 10 a shower as Resident 10 needed to be changed and cleaned up. Caregiver C stated all of a sudden, just before entering the shower, Resident 10 bent over in

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pain, passed out and they lowered Resident 10 to the floor. Caregiver C stated a very large piece of bowel movement came out of Resident 10 and then a large amount of blood mixed with diarrhea. At that time, they placed Resident 10 on the floor and ran to tell Medication Passer G who then called 911.

Caregiver C stated both Caregiver C and Caregiver F left the room so that Medication Passer G would be able to call and talk to 911 and provide the care. Caregiver C stated s/he believed the time was between 9-10:00 AM on 09/17/2022.

Surveyor asked if they opened the door or directed the EMS to the resident room. Caregiver C stated they attended to the other residents.

A review of EMS report dated 09/17/2022, noted the facility called for assistance at 10:23 AM and arrived at 10:30 AM. The report documented that no staff was awaiting their arrival. They located Resident 10 without staff assistance and found Resident 10 on the floor of the bathroom, "alone, laying in the bathroom just outside of the shower on the left side. Pt appears to be unresponsive, cool, dry and pale. Pt is nude except for a t-shirt that is around [his/her] neck only and an undergarment half off [his/her] person. Pt has a large pool of blood from [his/her] rectum and underneath [his/her] body. The shower in the is turn on and running. There is no staff present with the pt and none come when called." The report documented when staff were located, they were not able to answer questions, unable to provide medical history, demographics or other information.

At 10:49 AM EMS had transported Resident 10 to

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the ambulance then to local hospital.

A review of the hospital social services note dated 09/20/2022 indicated when EMS arrived, they were concerned that there was no staff with Resident 10 when Resident 10 was on the ground. According to the progress note, EMS reported that no staff were available to give a time frame and information related to the incident.

On 10/22/2022 at 4:33 PM, Surveyor interviewed Medication Passer G. Medication Passer G recalled the incident on 09/17/2022 and stated Medication Passer G entered Resident 10's bathroom, called 911 and attempted to look for medical papers to send with Resident 10 when EMS arrived. Medication Passer G stated Caregivers C and Caregiver F went out of the room and into other resident rooms to assist other residents. Medication Passer G stated s/he ran between the laundry room to get towels to clean up the floor and to get medical records. Executive Director B was also called at this time and had to provide a code to get into the office for the medical information. Medication Passer G stated s/he was writing down Resident 10 medications in a book at this time as well. Medication Passer G stated s/he was in and out of the room because s/he was not able to be in 2 places at the same time. Medication Passer G stated s/he had a hard time finding materials and towels.

On 10/26/2022, at 5:00 PM, through electronic correspondence, Surveyor interviewed EMS H regarding the 09/17/2022 incident. EMS H stated they arrived at Sylvan Crossing of Fitchburg and no staff were present to let them into the building. Resident 10 was found on the floor when EMS arrived. Resident 10 was dressed in a shirt which

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N 434	Continued From page 8 was up and around Resident 10's neck. Resident 10 had three diapers on, partially. Laying in a pool of blood. Resident 10 was completely alone the entire time EMS was present in the building. No staff attempted to gather blankets or towels nor render aid. EMS H stated all the information provided to EMS H and relayed to the hospital was from Resident 10's family member who was at the facility. EMS H stated they had limited information to provide the hospital.	N 434		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure that the clothes dryer was vented with tubing that was of rigid material. Findings include: On 10/18/2022, at approximately 9:20 AM, Surveyor toured the facility with Executive Director B (ED-B). Observed on the main floor laundry room, the 2 dryers were vented with flexible material. Plastic gloves were on the floor behind the dryer with an accumulation of lint. Surveyor asked ED-B why the dryer was not vented with rigid material. ED-B stated s/he was aware of the requirement but that they recently purchased new dryers and did not use the rigid	N 488		

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N 488	Continued From page 9 material. ED-B stated s/he would contact maintenance to switch out the venting material as s/he is aware that the vents should be rigid.	N 488		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not keep all rooms clean and free of odors. Findings include: On 10/18/2022, at approximately 9:30 AM, Surveyor toured the facility with Executive Director B (ED-B). Surveyor and ED-B entered Resident 6's room. A very strong urine-like odor was noted. Surveyor returned to the room at 10:53 AM, and the odor remained. Surveyor entered Resident 7's room and observed an accumulation of brown matter on the chair in the room. Surveyor returned to the room at 11:05 AM. The stained remained on the chair. At approximately 9:30 AM, Surveyor entered Resident 8's room and noted a very strong urine odor. Surveyor returned to the room at 11:07 AM, and the odor remained in the room. On 10/18/2022, at 2:30 PM, Surveyor interviewed ED-B about the odors. ED-B stated s/he detected the odors as well and was not sure why Resident 8's room contained an odor and stated Resident 6 is incontinent.	N 489		

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N 502	83.46(1)(a) Comfortable and safe temperatures A CBRF shall maintain comfortable and safe temperatures. The CBRF shall provide tempered air at all times to eliminate cold air drafts. The heating system shall be capable of maintaining temperatures of 74º F. in areas occupied by residents. This Rule is not met as evidenced by: Based on observation, resident interview and staff interview, the provider did not maintain a temperature of 74º F. in Resident 6's room. Findings include: On 10/18/2022, Surveyor toured the facility at approximately 9:20 AM. Surveyor entered Resident 6's room and noted the room felt very cold. At 10:53 AM, Surveyor interviewed Resident 6 who stated the room is always very cold and Resident 6 does not care for that. Resident 6 stated this concern was brought to the attention of Executive Director B but they were told the heat runs on a system. Resident 6 stated the heat in the room was not comfortable and at night, it gets very cold. Surveyor noted the room temperature was 63.7º F. at 11:01 AM. On 10/18/2022, at approximately 2:30 PM, Surveyor informed Executive Director B of the concern related to the cold room. Executive Director B did not provide any reason why the	N 502		

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N 502	Continued From page 11 room was not maintained at 74º F.	N 502		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure temperatures of water at fixtures used by residents did not exceed 115° F. of bathrooms tested exceeded 115° F. Findings include: On 10/18/2022 at approximately 11:00 AM, Surveyors toured the provider's facility. The provider is licensed to serve residents within the client groups of emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, terminally ill, advanced age. - Resident #6's sink water reached 123.4° F. Water tested 11:05 AM. - Resident #9's sink water reached 131.1° F. Water tested 11:08 AM. On 10/18/2022, Surveyor interviewed Resident 9 at approximately 11:00 AM. Resident 9 stated to	N 617		

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N 617	Continued From page 12 Surveyor that when Resident 9 received a shower, the water temperature gets very hot. - Resident 8's sink water reached 129.5 ° F. Water tested 11:16 AM. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (Source: Publication DHS P-01942 - 08/2017). On 10/18/2022 at approximately 2:30 PM, Surveyor reviewed water temperatures with Executive Director B (ED-B). ED B stated s/he was not aware that the temperatures reached that high and stated it would be addressed immediately.	N 617		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all	Y3234		

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Y3234	Continued From page 13 employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on record review and staff interview, Resident 10 was not treated with respect and full recognition of dignity on 09/17/2022, when they were assisted by staff to the bathroom, experienced a medical emergency and needed to be eased to the floor. Resident 10 was not clothed and laid on the bathroom floor unattended, while they experienced a GI Bleed. Emergency medical services arrived and observed that Resident 10 remained unclothed, on the bathroom floor in a pool of their own blood. Staff of Sylvan Crossings of Fitchburg did not cover Resident 10's body in an attempt to promote dignity. Staff did not stay with Resident 10 until EMS arrived. This is a repeat deficiency. See Statement of Deficiency NKN513 dated 01/02/2020. Findings include: Sylvan Crossings Of Fitchburg is a Class CNA (non-ambulatory) facility and was issued a regular license on 04/01/1997. The facility has a capacity to care for 19 adults and serve residents within the client groups of emotionally disturbed/mental illness, irreversible	Y3234		

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 _____	R-C 10/26/2022

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Y3234	Continued From page 14 dementia/Alzheimer's, terminally ill, advanced age. On 10/18/2022, Surveyor reviewed the record of Resident 10. Resident 10 was admitted to the provider on 10/31/2017 with a diagnoses including Dementia. According to the progress notes, on 09/17/2022, at 8:11 AM, staff gave Resident 10 an ensure drink. At 9:46 AM, staff returned to the room to administer morning medications and noted Resident 10 smelled of BM. The medication passer then asked staff to go in and change Resident 10. At 10:10 AM, as staff took Resident 10 to the bathroom, Resident 10 passed out and was lowered to the ground. They then saw blood and called Executive Director B who instructed staff to call 911. At 10:30 AM, Surveyor asked Executive Director B who was working with Resident 10 when the incident occurred. Executive Director B stated Caregiver C, Caregiver F and Medication Passer G. Surveyor asked Executive Director B and Operations Coordinator D about the events on 09/17/2022. Executive Director B and Operations Coordinator D stated they were not in the building at the time and really did not know exactly what had happened but that the code to the office was provided to Medication Passer G so that medical information could be located. Surveyor shared the concern about Resident 10 being on the floor without staff present, Executive Director B stated Medication Passer G was going between the laundry room and office and resident room at the time of the incident and Caregivers C and Caregiver F were very concerned about Resident 10 but believed the matter was being taken care of by Medication Passer G.	Y3234		

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Y3234	Continued From page 15 On 10/18/2022, at 11:20 AM, Surveyor interviewed Caregiver C. Caregiver C stated Caregiver C and Caregiver F assisted Resident 10 out of the bed, walked Resident 10 to the bathroom, turned on the shower as they prepared to give Resident 10 a shower as Resident 10 needed to be changed and cleaned up. Caregiver C stated all of a sudden, just before entering the shower, Resident 10 bent over in pain, passed out and they lowered Resident 10 to the floor. Caregiver C stated a very large piece of bowel movement came out of Resident 10 and then a large amount of blood mixed with diarrhea. At that time, they placed Resident 10 on the floor and ran to tell Medication Passer G who then called 911. Caregiver C stated both Caregiver C and Caregiver F left the room so that Medication Passer G would be able to call and talk to 911 and provide the care. Caregiver C stated s/he believed the time was between 9-10:00 AM on 09/17/2022. Surveyor asked if they opened the door or directed the EMS to the resident room. Caregiver C stated they attended to the other residents. A review of EMS report dated 09/17/2022, noted the facility called for assistance at 10:23 AM and arrived at 10:30 AM. The report documented that no staff was awaiting their arrival. They located Resident 10 without staff assistance and found Resident 10 on the floor of the bathroom, "alone, laying in the bathroom just outside of the shower on the left side. Pt appears to be unresponsive, cool, dry and pale. Pt is nude except for a t-shirt that is around [his/her] neck only and an undergarment half off [his/her] person. Pt has a large pool of blood from [his/her] rectum and	Y3234		

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Y3234	Continued From page 16	Y3234		

underneath [his/her] body. The shower in the is turn on and running. There is no staff present with the pt and none come when called." The report documented when staff were located, they were not able to answer questions, unable to provide medical history, demographics or other information.

At 10:49 AM EMS had transported Resident 10 to the ambulance then to local hospital.

A review of the hospital social services note dated 09/20/2022 indicated when EMS arrived, they were concerned that there was no staff with Resident 10 when Resident 10 was on the ground.

On 10/22/2022 at 4:33 PM, Surveyor interviewed Medication Passer G. Medication Passer G recalled the incident on 09/17/2022 and stated Medication Passer G entered Resident 10's bathroom, called 911 and attempted to look for medical papers to send with Resident 10 when EMS arrived. Medication Passer G stated Caregivers C and Caregiver F went out of the room and into other resident rooms to assist other residents. Medication Passer G stated s/he ran between the laundry room to get towels to clean up the floor and to get medical records. Executive Director B was also called at this time and had to provide a code to get into the office for the medical information. Medication Passer G stated s/he was writing down Resident 10 medications in a book at this time as well. Medication Passer G stated s/he was in and out of the room because s/he was not able to be in 2 places at the same time. Medication Passer G stated s/he had a hard time finding materials and towels.

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Y3234	Continued From page 17 On 10/26/2022, at 5:00 PM, through electronic correspondence, Surveyor interviewed EMS H regarding the 09/17/2022 incident. EMS H stated Resident 10 was found on the floor when EMS arrived. Resident 10 was dressed in a shirt which was up and around Resident 10's neck. Resident 10 had three diapers on, partially. Laying in a pool of blood. Resident 10 was completely alone the entire time EMS was present in the building. No staff attempted to gather blankets or towels nor render aid. Summary: Resident 10 was not treated with respect and full recognition of dignity on 09/17/2022, when Resident 10 was assisted by staff to the bathroom, experienced a medical emergency, needed to be eased to the floor. Resident 10 was not clothed, laid on the bathroom floor, unclothed and experienced a GI Bleed. Emergency medical services arrived, observed Resident 10, unclothed, on the bathroom floor in a puddle of excrement and blood. Staff of Sylvan Crossing Fitchburg did not attempt to cover Resident 10 in an attempt to promote dignity.	Y3234		