Wisconsin Department of Health Services

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 07/21/2026

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 07/21/2026, Surveyors conducted a complaint investigation at Hyland Crossings. One deficiency was identified. The complaint was unsubstantiated. Census: 24	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. 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. This Rule is not met as evidenced by: 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 was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of resident or employees. On 06/01/2026, police responded to the facility related to Resident 1's behaviors. Findings include: On 07/21/2026, Surveyor reviewed Resident 1's record and identified the following:	N 164		

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 07/21/2026

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 164	Continued From page 1 Resident 1 admitted to the facility on 04/11/2026 with a diagnosis of Alzheimer's disease. Resident 1 had an activated healthcare power of attorney. On 07/21/2026, Surveyor reviewed Resident 1's record. Resident 1's progress notes documented: "06/01/2026: Writer called 911 because resident was being physically aggressive towards staff and would not let staff provide cares to another resident. Resident was very upset and was yelling at staff grabbing at them and squeezing their arms and wrists. Resident bent writers finger back and would not let go and grabbed a staff members shoulders to push [him/her] out of the way when staff were trying to care for another resident. Staff tried to redirect resident multiple times with different approaches and resident just kept getting more agitated. 911 arrived when resident was sitting in common area with other residents. Resident refused to be sent out and POA agreed to stay and calm resident down. POA took resident out for a walk and will call doctor for further recommendations." Resident 1's 30 Day Discharge Notice dated 06/05/2026 documented: " .....On 6/1/2026, [Resident 1] was physically aggressive towards staff and would not let staff provide cares to another resident. [Resident 1] was grabbing at staff, squeezing their arms and wrists, bending their fingers back, and pushed one staff member into the wall. Due to this physical aggression and for the safety of staff and residents, we did contact 911 on this date as well as you to assist. We informed you on this date that if [s/he] were to harm a resident, it would result in a discharge notice." On 07/21/2026, Surveyor reviewed Department records. There was no self-report in the	N 164		

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 07/21/2026

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 164	Continued From page 2 Department files regarding Resident 1's incident on 06/01/2026. On 07/21/2026 at 1:13 PM, Surveyor interviewed Executive Director A regarding the missing self-report for Resident 1's law enforcement incident on 06/01/2026. Executive Director A reported after checking their system, the provider did not submit a self-report to the Department. Executive Director A stated the provider forgot.	N 164		