

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/02/2026
NAME OF PROVIDER OR SUPPLIER SIENNA CREST DEFOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 506 BASSETT ST DE FOREST, WI 53532		
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N 000	Initial Comments On 06/25/2026, with information obtained through 07/02/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Sienna Crest Deforest, a community-based residential facility (CBRF) located in DeForest, WI. As a result of the survey, 1 deficiency was identified. The complaint was substantiated. Census: 11	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 record review and interview, the provider did not ensure that Resident 1 received prompt treatment appropriate to his/her needs when s/he became unresponsive and experienced low oxygen saturation levels. Findings include: On 06/25/2026, Surveyor conducted an investigation into allegations involving prompt and adequate responses to resident needs. On 06/25/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider	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 03/21/2026 with diagnoses including chronic obstructive pulmonary disease (COPD) and moderate cognitive impairment. Resident 1 resided with the provider until 05/06/2026 when s/he was admitted to the emergency department out of concerns for a stroke and subsequently hospitalized. Resident 1 passed away while hospitalized. Resident 1 was documented as having an activated power of attorney for healthcare (POA). While with the provider, Resident 1 received hospice services. Resident 1's individual service plan (ISP), not dated, documented that Resident 1 was "on continuous Oxygen/ with distilled water concentrator." Resident 1's observation notes included the following entries: - 05/06/2026: "...Resident was sitting in a chair in the living room and leaned over to the left and went unresponsive manager called family and hospice. Hospice [registered nurse] came and said [s/he] had a stroke and should go to the [emergency room]. Family called manager and said resident had a [large] brain bleed. Family will notify manager with updates..." - 05/08/2026: "Manager note - manager was told by family that [s/he] had passed..." At approximately 10:45 a.m., Surveyor interviewed Caregiver C. Caregiver C confirmed that Resident 1 required continuous supplemental oxygen and reported that Resident 1 required staff assistance to manage his/her supplemental oxygen. This included switching him/her from his/her regular concentrator to his/her portable concentrator (and vice versa), cuing to keep his/her nasal cannula on, and charging his/her portable concentrator.	N 353		

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N 353	Continued From page 2 At approximately 11:15 a.m., Surveyor interviewed Caregiver D. Caregiver D confirmed that Resident 1 required continuous supplemental oxygen and reported that Resident 1 required staff assistance to manage his/her supplemental oxygen. This included switching him/her from his/her regular concentrator to his/her portable concentrator (and vice versa), cuing to keep his/her nasal cannula on, and charging his/her portable concentrator. At approximately 11:55 a.m., Surveyor interviewed Manager B. Manager B confirmed that staff assisted Resident 1 with managing his/her supplemental oxygen, including switching him/her from his/her regular concentrator to his/her portable concentrator (and vice versa) and charging his/her portable concentrator. Manager B reported that Resident 1 received a continuous flow of oxygen at the rate of 3 liters per minute (LPM). Manager B reported that staff never adjusted this level and would be expected to contact hospice if issues with Resident 1's oxygen arose. Regarding the documented episode of Resident 1's unresponsiveness on 05/06/2026, Manager B reported that s/he was called over by a caregiver and when s/he entered the area s/he observed Resident 1 in the common area, leaning to his/her side. Manager B reported that Resident 1 wouldn't answer questions. Manager B reported s/he called Family Member E, who was Resident 1's POA, to notify him/her of the situation. Manager B reported that Family Member E replied to him/her on the phone s/he was on his/her way to the facility. Manager B reported s/he thought that based on that response Family Member E would arrive to the facility shortly. Manager B reported that after while when Family	N 353			

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N 353	Continued From page 3 Member E still hadn't shown, s/he called him/her again saying s/he planned to call Resident 1's hospice agency, to which Family Member E was agreeable. Manager B reported that Family Member E was known to want to make all decisions related to Resident 1's care and medical needs, and that was why Resident 1's hospice agency was not called right away. Manager B reported s/he thought it was approximately 20 minutes from the time s/he first saw Resident 1 until the time hospice was contacted. Manager B reported that s/he then called Resident 1's hospice agency and was directed by hospice staff to prop up Resident 1 in an upright sitting position. Manager B reported s/he recalled checking Resident 1's oxygen saturation levels at various points during this and that at one point s/he had a value of 62%. Manager B reported that when Family Member E arrived to the facility, s/he switched Resident 1 from his/her portable oxygen concentrator (which s/he had been on during this episode), to his/her room/stationary concentrator, which seemed to help. Manager B reported recalling that Resident 1's oxygen saturation level improved but s/he still was not talking or being responsive with eye contact. On 06/29/2026, at approximately 3:31 p.m., Surveyor interviewed Family Member E, who was Resident 1's POA, about the unresponsive episode on 05/06/2026. Family Member E reported s/he received a call from Manager B at approximately 4:48 p.m. in which s/he was informed that Resident 1 was unresponsive. Family Member E reported being told that initially Resident 1 sat on a chair and was talking but then closed his/her eyes and only answered yes/no questions and then ultimately stopped answering questions at all. Family Member E	N 353		

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N 353	Continued From page 4 reported that based on his/her review of his/her phone call log, there was another phone call between him/her and staff at 4:54 p.m. (approximately 6 minutes after the last call). Family Member E reported that during one of the phone calls Manager B reported to him/her that s/he had not yet called Resident 1's hospice agency. Family Member E reported s/he told Manager B to call Resident 1's hospice agency. Family Member E reported after arriving onsite, which was approximately 15 minutes from the time s/he received the first phone call, s/he was informed by Manager B that Resident 1's oxygen saturation level was at 66%. Family Member E reported s/he retrieved Resident 1's room/stationary concentrator and switched Resident 1 from his/her portable concentrator to the room one. Family Member E reported that after this, s/he recalled Resident 1 being able to open his/her eyes. Family Member E reported that on later retests, Resident 1's oxygen saturation level was at 97% or 98%. Family Member E reported, "Hospice should have been the first call," in relation to Resident 1's unresponsive episode. On 06/29/2026, Surveyor reviewed Resident 1's hospice records. A note dated 05/06/2026 documented that a phone call from Manager B came in at 5:02 p.m. out of concerns for Resident 1 experiencing an altered mental status, with specific concerns noted for: "decrease in responsiveness and leaning to left side, will not open eyes, shaking head when questions are asked..." The note documented that it was reported Resident 1 appeared to be in distress or discomfort as evidenced by "squinting left eye and pointing to right temple." The note indicate that this change occurred "10 minutes ago" from the time of the call.	N 353		

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N 353	Continued From page 5 The narrative of the note documented, "Caller reports that [patient (pt)] is in a chair laying to left of chair, will not open eyes. Caller reports that pt shakes head with answering questions, but also had parkinson's and occasionally twitches. Caller reports that pt has oxygen on at 3LPM. Caller reports that [vitals] taken just now [blood pressure] 152/62, pulse 92, and [oxygen] sat[uration] 66%..." The note also documented, "...writer educated to turn [oxygen] up to 4LPM and to sit pt up as much as possible to allow [his/her] lungs to properly fill. Writer educated that [agency] nurse will be sent out urgently to visit..." According to the National Institutes of Health (NIH), hypoxemia is characterized by "low oxygen content in the blood" and can contribute to hypoxia, which "occurs when oxygen is insufficient at the tissue level..." A resting oxygen saturation of less than 95% is considered abnormal, and the brain can develop changes when saturations are less than 80-85%. Pulse oximetry, a tool to measure oxygen saturation, "can provide a rapid tool to assess oxygenation accurately," and, "is extremely useful because the signs and symptoms of [low oxygen in the blood] may not be visible on physical examination," (Sources: NIH: National Library of Medicine, Hypoxia and Hypoxemia, Marcy 4, 2024, https://www.ncbi.nlm.nih.gov/books/NBK482316/#:~:text=Hypoxia%20is%20a%20state%20in,in%20the%20blood%20(hypoxemia) (retrieval date - July 2, 2026); NIH: National Library of Medicine, Oxygen saturation, November 23, 2022, https://www.ncbi.nlm.nih.gov/books/NBK525974/ (retrieval date - July 2, 2026).).	N 353		