STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0008694	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA CREST MINERAL POINT	210 COPPER ST , MINERAL POINT, Wisconsin, 53565

(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) COMPLETION DATE
N0000	Initial Comments On 10/13/2026, the bureau of assisted living southern regional office conducted a standard survey and complaint investigation at Sienna Crest a CBRF located in Mineral Point, WI. As a result of the survey, 4 violations of DHS Chapter 83 were identified. The complaint was substantiated. Census: 16	N0000		
N0164	Reporting when law enforcement is called. CFR(s): 83.12(4)(b) 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the department within 3 working days after law enforcement personnel were called to the CBRF because of an incident that jeopardized the health, safety, or welfare or residents or employees. FINDINGS INCLUDE: On 09/23/2026, the department received a complaint with allegations of inadequate resident treatment.	N0164		

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

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N0164	Continued from page 1 On 10/13/2026, Surveyor arrived at the facility for a complaint investigation. On 10/13/2026, Surveyor reviewed a police report dated 07/20/2026, case number 07-26-58. Police were called because Resident 1 had eloped out of the facility and entered a private residence. Resident 1 refused to follow staff re-direction to the facility. Police met Resident 1 in the kitchen of the private residence. Police then transported Resident 1 back to the facility where s/he met with Family Member F. On 10/13/2026, Surveyor reviewed a police report dated 08/15/2026, case number 08-26-42. The following was documented, "On 8/15/26 at 1:09 PM, I was dispatched to [Name Of Facility] for a client that had left the complex. Upon arrival, I met with [Resident 1] and [Caregiver D] on [Name of Street] near the park. [Resident 1] is a resident in the memory care unit and not allowed to leave unaccompanied. [Resident 1] wanted to go for a walk and became aggressive with [Caregiver D] and grabbed [his/her] arms and tried to hit [him/her]. [Resident 1] walked back to [Name Of Facility]. Staff there advised this is not the first time this has happened and they would like [Resident 1] to leave. [Family Member E], advised [s/he] would take [Resident 1] and see if the behavior improves." On 10/13/2026 at approximately 10:00AM, Surveyor request all self-report sent to the Department since 08/01/2026 from Administrator A. On 10/13/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 06/12/2026. Resident 1 had a guardian. Resident 1's individualized service plan dated 07/22/2026 documented Resident 1 as requiring 24 hours supervision and, " ...wandering risk, elopement risk, Combative (sic.) behaviors, Dangerous (sic.) agitation ..." On 10/13/2026, Surveyor reviewed Resident 1's incident report dated 08/15/2026. Caregiver D documented, " ...Staff member approach trying to calm the resident down to come back to the building resident took off running (sic.) Staff member followed then third staff called non emergency (sic.) [Name Of Town] Police arrived got resident to come back to building ..."	N0164		

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N0164	Continued from page 2 On 10/13/2026 at 1:50 PM, Surveyor discussed the above concerns with Administrator A and Licensee B. Administrator A stated self-reports were not sent to the Department for the incidents on 07/20/2026 and 08/15/2026. Administrator A and Licensee B acknowledged police personnel were at the facility on 07/20/2026 and 08/15/2026. CROSS REFERENCE: N0389 DHS Chapter 83.35(3)(d) Service Plans Updated Annually Or On Changes CROSS REFERENCE: N0410 DHS Chapter 83.37(1)(k) Medication Error Or Adverse Reaction	N0164		
N0220	Employees screened for communicable disease. CFR(s): 83.17(2)(a) The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 3 caregivers reviewed had been screened for tuberculosis (TB) using centers for disease control (CDC) and prevention standards. FINDINGS INCLUDE: The Center for Disease Control and Prevention (CDC) guidelines for tuberculosis screening for health care workers (HCWs) are as follows, "TB Screening Procedures for Settings (or HCWs) Classified as Low Risk ... All HCWs should receive baseline TB screening upon hire, using two-step TST (tuberculin skin test) or a single BAMT (blood test measuring interferon gamma protein) to test for infection with	N0220		

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N0220	Continued from page 3 M. tuberculosis. After baseline testing for infection with M. tuberculosis, additional TB screening is not necessary unless an exposure to M. tuberculosis occurs...HCWs with a baseline positive or newly positive test result for M. tuberculosis infection (i.e., TST or BAMT) or documentation of treatment for LTBI or TB disease should receive one chest radiograph result to exclude TB disease (or an interpretable copy within a reasonable time frame, such as 6 months) ...". (Source: The Center for Disease Control and Prevention Website, Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, December 30, 2005, https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm (retrieval date - October 13, 2026).) On 10/13/2026, Surveyor arrived for a standard survey. EXAMPLE 1: Caregiver G On 10/13/2026, Surveyor reviewed Caregiver G's staff record. Caregiver G was hired on 10/26/2022. Caregiver G had been screened for TB using a 1-step TST completed on 10/20/2022. EXAMPLE 2: Caregiver H On 10/13/2026, Surveyor reviewed Caregiver H's staff record. Caregiver H was hired on 09/08/2025. Caregiver H had been screened for TB using a 1-step TST completed on 09/10/2025. EXIT INTERVIEW: On 10/13/2026 at 1:50 PM, Surveyor discussed the above concerns with Administrator A and Licensee B. Administrator A stated s/he hadn't realized CDC required 2-step TST, BAMT blood test, or chest x-ray to screen caregivers in long-term care for TB. Administrator A acknowledged Caregiver G nor Caregiver H had been screen for TB utilizing CDC prevention standards.	N0220		
N0389	Service plans updated annually or on changes CFR(s): 83.35(3)(d)	N0389		

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N0389	Continued from page 4 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 involvement in, understanding of and agreement with the individual service plan. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individualized service plan (ISP) was updated when there was a change in his/her needs, abilities, physical or mental condition or that Resident 1's legal representative signed the ISP, acknowledging their involvement in, understanding of and agreement with the ISP. FINDINGS INCLUDE: On 09/23/2026, the department received a complaint with allegations of inadequate resident treatment. On 10/13/2026, Surveyor arrived at the facility for a complaint investigation. On 10/13/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 06/12/2026. Resident 1 had a guardian. Resident 1 was diagnosed with but not limited to chronic constipation. On 10/13/2026 at 9:20AM, Surveyor interviewed Family Member E over the phone. Family Member E stated that on 08/15/2026 Resident 1 eloped from the facility and became combative with staff. Family Member E reported that Caregiver C had called him/her and local police in response. Family Member E stated that Caregiver C told them Resident 1 had go either go to the local dementia re-stabilization unit or go home with Family Member E. Family Member E stated s/he decided to take Resident 1 home due to the abrupt discharge by Caregiver C. Family Member E reported that Resident 1 had a long history of constipation, bowel	N0389		

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N0389	Continued from page 5 obstruction secondary to his/her diagnosis of Ogilvie syndrome. Family Member E reported facility was made aware for Resident 1's history of complex bowel issues prior to admission earlier this Summer. Family Member E reported that Resident 1's behaviors will become more aggressive with increased pain and/or constipation. Family Member E stated Resident 1 cannot verbalize pain or constipation due to his/her dementia diagnosis. Family Member E stated s/he can usually tell if Resident 1 is having constipation or bowel obstruction if his/her abdomen is grossly distended. Family Member E stated when s/he got Resident 1 back to his/her house, s/he noticed Resident 1's abdomen was distended and s/he didn't have an appetite. Family Member E stated s/he then transported Resident 1 to the local ER, and then admitted to an inpatient unit for treatment of a small bowel obstruction. Family Member E stated Resident 1 was admitted to the hospital and didn't display any aggressive behaviors towards medical staff while s/he was receiving treatment to alleviate the small bowel obstruction. On 10/13/2026, Surveyor reviewed Resident 1's hospital record dated 07/04/2026. Resident 1's was admitted to inpatient for treatment of, "Diagnosis ...Intestinal obstruction, unspecified cause ..." Resident 1's was discharged back to the facility on 07/08/2026 with the following discharge orders included starting 2 new medications a stool softener docusate sodium 100mg capsules twice daily for loose stools and laxative powder psyllium 100% powder, along with "Discharge Procedure Orders ...Oxygen saturation - Check PRN (as needed) for respiratory distress or change in patient's condition per RN assessment ...Notify Physician if ...Patient's weight increases or decreases by 3 lbs in one day or 3 lbs in one week ..." On 10/13/2026, Surveyor reviewed Resident 1's urgent care after visit summary dated 07/22/2026. Resident 1's was discharged back to the facility that same day with the following discharge instructions, "...Instructions...I recommend [s/he] drink plenty of water and try to eat as much fiber as possible. Add the MiraLAX daily to help resolve [his/her] constipation...[S/He] should return to the emergency department for vomiting abdominal pain, fever, or other concerns..." .	N0389		

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N0389	Continued from page 6 On 10/13/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 07/22/2026 was not signed by Resident 1 or his/her guardian (Family Member E). Resident 1's ISP documented that s/he had been hospitalized for a bowel obstruction on 07/04/2026 but did not contain the discharge orders to monitor for respiratory distress or the physician's order to complete daily weight measurements. The ISP didn't mention the addition of increased dietary fiber. The ISP didn't mention that Resident 1 had a history of increased abdominal distention (bloating) and/or behavior escalation in response to development of severe constipation and/or bowel obstruction. EXIT INTERVIEW: On 10/13/2026 at 1:50 PM, Surveyor discussed the above concerns with Administrator A and Licensee B. Administrator A reported it was difficult to assess Resident 1's abdomen because s/he was a very private person. Administrator A reported s/he had noticed Resident 1's abdomen would become distended (bloated) when s/he was constipated. Administrator A acknowledged Resident 1's, nor his/her legal guardian (Family Member E) had signed his/her ISP when it was updated on 07/22/2026. Administrator A acknowledged Resident 1's ISP hadn't been updated to reflect the physician order to monitor his/her daily weight nor a plan to assess/intervene when s/he was becoming more constipated or developing a bowel obstruction. CROSS REFERENCE: N0164 DHS Chapter 83.12(4)(b) Reporting When Law Enforcement Is Called CROSS REFERENCE: N0410 DHS Chapter 83.37(1)(k) Medication Error Or Adverse Reaction	N0389		
N0410	Medication error or adverse reaction. CFR(s): 83.37(1)(k) Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or	N0410		

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N0410	Continued from page 7 pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure a report was made to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refused medication for 2 consecutive days. From 08/01/2026 to 08/15/2026, Resident 1 refused multiple medications. The prescribing practitioner(s) weren't notified of the medication refusals. FINDINGS INCLUDE: On 09/23/2026, the department received a complaint with allegations of inadequate resident treatment. On 10/13/2026, Surveyor arrived at the facility for a complaint investigation. On 10/13/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 06/12/2026. Resident 1 had a guardian. Resident 1 was diagnosed with but not limited to chronic constipation. On 10/13/2026, Surveyor reviewed Resident 1's hospital record dated 07/04/2026. Resident 1's was admitted to inpatient for treatment of, "Diagnosis ...Intestinal obstruction, unspecified cause ..." Resident 1's was discharged back to the facility on 07/08/2026 with the following discharge orders included starting 2 new medications a stool softener docusate sodium 100mg capsules twice daily for loose stools and laxative powder psyllium 100% powder, along with "Discharge Procedure Orders ...Oxygen saturation - Check PRN (as needed) for respiratory distress or change in patient's condition per RN assessment ...Notify Physician if ...Patient's weight increases or decreases by 3 lbs in one day or 3 lbs in one week ..."	N0410		

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N0410	Continued from page 8 On 10/13/2026, Surveyor reviewed Resident 1's hospital record. On 08/15/2026, The emergency department documented the following, " ... [Resident 1] ...who presents to the Emergency Department for evaluation of chest pain. About 45 minutes prior to arrival the patient woke [Family Member E] and stated [s/he] had pain in the center of [his/her] chest. The pain did not radiate ... [Family Member E] notes that [his/her] abdomen looks bloated here. The patient denies any abdominal pain. [S/he] had 3 loose bowel movements yesterday ...[S/he] was admitted to the hospital 8/15/2026-8/20/2026 for acute colonic pseudo-obstruction/Ogilvie's syndrome." On 10/13/2026, Surveyor reviewed Resident 1's August 2026 medication administration record (MAR). The following was documented: 1.) "*RAW PROBIOTIC* TAKE 3 CAPSULES BY MOUTH ONCE DAILY IN THE MORNING WITH BREAKFAST..." From 08/01/2026 to 08/15/2026, the medication was documented as "refused." 2.) "*BETTER BONES BUILDER MULTIVITAMIN* TAKE 3 CAPSULES ONCE DAILY IN THE MORNING WITH BREAKFAST ..." From 08/01/2026 to 08/15/2026, the medication was documented as "refused." 3.) "FISH OIL 1000MG SOFTGEL TAKE 1 CAPSULE BY MOUTH ONE TIME DAILY IN THE MORNING WITH BREAKFAST ..." From 08/01/2026 to 08/10/2026, the medication was documented as "refused." 4.) *AMAZING GRASS SUPPLEMENT* MIX 1 SCOOP IN WITH 8-12OZ OF A SMOOTHIE ONCE DAILY WITH BREAKFAST ..." From 08/01/2026 to 08/15/2026, the medication was documented as "refused." 5.) "Daily Weight Notify MD if weight increases or decreases by 3 lbs in one day or 3lbs in one week ..." From 08/01/2026 to 08/15/2026, the measurement was documented as refused. EXIT INTERVIEW:	N0410		

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N0410	Continued from page 9 On 10/13/2026 at 1:50 PM, Surveyor discussed the above concerns with Administrator A and Licensee B. Administrator A reported s/he wasn't aware facility was required to report if a medication had been refused for 2 consecutive days to the prescribing doctor. Administrator A reported the refusals documented on Resident 1's August 2026 MAR were not reported to the prescribing practitioner's after 2 consecutive days. Administrator A acknowledged Resident 1 had a complex bowel history and s/he had refused his/her probiotic for approximately 15 days and ordered daily weights. Administrator A acknowledged the daily weights had been ordered following hospitalization for intestinal obstruction in July 2026. CROSS REFERENCE: N0164 DHS Chapter 83.12(4)(b) Reporting When Law Enforcement Is Called CROSS REFERENCE: N0389 DHS Chapter 83.35(3)(d) Service Plans Updated Annually Or On Changes	N0410		