STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019133	A. BUILDING: _____ B. WING _____	R-C 11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA CREST DEFOREST	506 BASSETT ST DE FOREST, WI 53532

(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 11/11/2025, Surveyor conducted a verification visit at Sienna Crest DeForest, a CBRF in DeForest. One deficiency was identified. This is a repeat deficiency. See Statement of Deficiency (SOD) QZO111, dated 07/07/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 12	{N 000}		
{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 or dietician. 3. The CBRF shall document	{N 431}		

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

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{N 431}	Continued From page 1 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 1 of 3 residents reviewed had their health monitored and documented in his/her record. Resident 1's podiatry wound care was not monitored and documented as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) QZO111, dated 07/07/2025. Findings include: On 11/11/2025 at 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 09/03/2024 with diagnoses including diabetes and heart failure. On 11/11/2025 at 10:10 a.m., Surveyor interviewed Manager A about Resident 1. Manager A indicated Resident 1 had gone to the hospital for a follow-up for his/her foot. Manager A believed s/he might have had a MRSA (methicillin-resistant staphylococcus aureus) infection and shingles. Manager A was unsure if Resident 1 would return to the facility. Surveyor inquired about Resident 1's foot. Manager A said Resident 1 needed a bandage change one time per week on shower days. On 11/11/2025 at 10:23 a.m., Surveyor reviewed Resident 1's podiatry After Visit Summary, dated	{N 431}		

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{N 431}	Continued From page 2 10/06/2025. Resident 1 had gone to the podiatrist for the following issues: non-pressure chronic ulcer of the left foot with fat layer exposed and cellulitis of the left foot. An open wound debridement on his/her left foot had been performed that day. The podiatry wound care instructions were as follows: "Location: left medial forefoot. Frequency: once daily. -Remove old dressing. -Wash hands with soap and water. -Cleanse wound with antibacterial soap and water with gentle friction. Rinse and pat dry. -Apply Cavilon skin barrier to the intact skin to the wound periphery and allow to dy. -Apply a felt offloading pad to the wound periphery to offload pressure/friction. This felt pad does not need to be changed daily if it does not become soiled. -Apply lodosorb ...to wound using a cotton-tipped applicator. Do not touch the wound with the tip of the lodosorb in an effort to avoid cross-contamination. -Cover with a small square of calcium alginate (for improved absorbency), then dry gauze. Wrap in place with 2-in or 4-in gauze, anchoring at the ankle. Avoid placing tape directly on the skin. -Wear compression stockings to decrease swelling. -Wear the surgical sandal which was provided at the podiatry clinic whenever standing or walking. Please contact our clinic and seek further care if: 1. Increased swelling, redness, or pain around the wound. 2. A red streak extending away from the wound. 3. Thick white, yellow, green, or bloody drainage coming from the wound. 4. Fever over 100.0 degrees F. " On 11/11/2025 at 10:30 a.m., Surveyor reviewed	{N 431}		

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{N 431}	Continued From page 3	{N 431}		

wound care instructions with Manager A and asked how staff knew this was supposed to be done and how it was being documented. Manager A indicated the wound care was not documented anywhere after it was done, but s/he had printed off the instructions and included them with a significant change form in Resident 1's Medication Administration Record (MAR). Manager A had also placed the instructions in Resident 1's room. Manager A indicated no observation notes were kept by staff, but said they told Manager A the wound looked the same every day and Manager A was being told the wound care was done every day.

On 11/11/2025 at 10:55 a.m., Manager A clarified Resident 1 had gone to the podiatrist for a follow-up appointment on 10/14/2025 and they had sent Resident 1 straight to the hospital.

On 11/11/2025 at 11:10 a.m., Surveyor reviewed concern that Resident 1's record did not include documentation of his/her care and monitoring of his/her wound, which s/he was currently hospitalized for with Manager A, Administrator C, and HR Manager E. Manager A reviewed Resident 1's wound care instructions again and stated that it looked like a lot of instructions, but they were actually simple. Manager A insisted the wound care had been done, but HR Manager E reminded him/her, "If you didn't document it, it didn't happen." Manager A took note of the concern.

On 11/18/2025 at 7:05 p.m., Surveyor received Resident 1's hospital report, dated 10/24/2025, which stated Resident 1 had been admitted to the hospital from 10/14/2025 to 10/24/2025. Resident 1's hospital course summary included the following

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{N 431}	Continued From page 4 information, in part: "1. Left diabetic foot infection with ulcer and cellulitis, concern for residual osteomyelitis. Prior to admission, was on treatment with Augmentin via podiatry, prescribed 10-day's worth on 10/6 for a new full thickness ulcer; [Resident 1] followed up in clinic on 10/14 and was noted to have worsening of the wound. [Resident 1] was then sent from podiatry clinic to the ER (Emergency Room). [Resident 1] did have erythema (redness) around the ulcer on [his/her] left foot with apparent failure of Augmentin for treatment of SSTI (skin and soft tissue infection). A left foot x-ray was without evidence of osteomyelitis. [Resident 1] was treated with broad spectrum antibiotics and a wound culture was obtained which ultimately grew MRSA and pan-sensitive Pseudomonas. ...A PICC (peripherally inserted central catheter) line was placed and follow-up in the infectious disease clinic has been requested."	{N 431}		