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
	111052	A. BUILDING: _____ B. WING _____	R 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA CREST MARSHALL	604 LEWELLEN ST MARSHALL, WI 53559

(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 04/16/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a remote verification visit at Sienna Crest Marshall, a community-based residential facility (CBRF) located in Marshall, WI. As a result of the survey, 0 deficiencies were identified. The previous deficiency from Statement of Deficiency (SOD) VP0O11, dated 01/19/2024, was corrected. Census: 16	N 000		

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