STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017763	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA MEADOWS DEFOREST	504 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 03/10/2026, Surveyor conducted a self-report review at Sienna Meadows DeForest. As a result of the investigation, 1 violation of Chapter DHS 83 was issued.	N 000		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure adequate supervision of a resident, resulting in an elopement in which Resident 1 exited the facility unsupervised and his/her whereabouts were unknown for a period of at least 30 minutes. Findings On 02/12/2026, the facility submitted a self-report to the Department indicating that Resident 1 eloped from the facility on 02/11/2026. Resident 1 was returned to the facility by Deforest Police after a nearby business contacted 911 to report a confused individual on their property. Law Enforcement Report Review	N 426		

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
	0017763	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA MEADOWS DEFOREST	504 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 426	Continued From page 1 On 03/09/2026, the Surveyor reviewed a Deforest Police Department report dated 02/11/2026. The report indicated that at approximately 1:49 PM, law enforcement responded to a call regarding an individual wandering outside a local business. Upon contact, Resident 1 was only able to state his/her name and was unable to recall his/her date of birth, home address, or how to return to the facility. Resident 1 could not indicate how long s/he had been walking or why s/he left the facility. The report further indicated: Resident 1 was last observed at the facility eating lunch at approximately 12:00 PM and was last seen in the building at approximately 12:45 PM. Resident 1 exited the facility through the front entrance, which is equipped with an alarm system. Facility staff were unaware that Resident 1 was missing at the time law enforcement returned him/her to the facility. Staff were unable to confirm whether the door alarm had sounded or whether staff responded to it. Resident 1 was returned to the facility by police at approximately 2:10 PM. Resident Record Review On 03/10/2026 at 9:00 AM, the Surveyor reviewed Resident 1's medical record. Resident 1 was admitted on 08/19/2019 with diagnoses including, but not limited to: Dementia/Alzheimer's disease Delusions and paranoid thinking Adjustment disorder Anxiety and depression Diabetes Type II Insomnia The record indicated that Resident 1 had no prior	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017763	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA MEADOWS DEFOREST	504 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 426	Continued From page 2	N 426		

history of elopement since admission; however, Resident 1 routinely sat on the porch unsupervised and had a tendency to answer the door before staff. Staff were to keep Resident 1 in line of sight when on the porch.

Facility Investigation and Disciplinary Review
On 03/10/2026, the Surveyor reviewed facility investigation documentation related to the incident dated 02/11/2026. Documentation indicated that Resident 1 exited the building and was later located across the street at a local business.

The Surveyor also reviewed disciplinary documentation dated 02/11/2026 for both Caregiver B and Caregiver C. Documentation stated:
"Review of the incident determined that proper monitoring procedures and door alarm awareness protocols were not followed at the time. This resulted in a safety risk."

Staff Interviews
Caregiver B Interview (03/10/2026 at 10:00 AM):
Caregiver B reported that the facility was busy at the time of the incident, stating, "We had just finished serving lunch and were assisting residents with toileting." Caregiver B further stated that the door alarm was sounding frequently due to a visitor entering and exiting the building.
Caregiver B reported last observing Resident 1 at approximately 1:20 PM walking toward his/her room. Not seeing Resident 1 again until law enforcement returned him/her to the facility at approximately 2:00-2:05 PM.
Awareness that staff are required to respond each time the door alarm sounds to ensure resident safety. Caregiver B acknowledged, "We

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017763	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA MEADOWS DEFOREST	504 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 426	Continued From page 3	N 426		

are supposed to go to the door each time that the alarm sounds ... That did not happen that day since Resident 1 walked away," and confirmed receiving disciplinary action along with Caregiver C for failure to respond to the alarm.

Licensee A Interview (03/10/2026 at 9:30 AM):
Licensee A stated that Resident 1 has resided at the facility since 2019 and had not previously eloped. Licensee A described Resident 1 as generally independent, not requiring assistive devices for ambulation, and noted that Resident 1 is allowed to sit on the porch unsupervised. Licensee A confirmed the front entrance door is equipped with an alarm that sounds when opened and stops when closed. Staff are required to respond each time the alarm sounds. Licensee A acknowledged that staff likely failed to respond appropriately to the alarm on 02/11/2026, stating, "If they would have responded, Resident 1 would not have gotten very far and may not have been considered an elopement."

Environmental Conditions
According to Weather.com, outdoor temperatures in Deforest, Wisconsin on 02/11/2026 ranged from approximately 22°F to 40°F, presenting additional risk to Resident 1 due to prolonged exposure while unsupervised.

Conclusion
Based on interview and record review, the provider failed to ensure adequate supervision and monitoring of Resident 1. Staff did not follow established door alarm response protocols, resulting in Resident 1 exiting the facility undetected. The provider did not identify the resident as missing and initiate a timely response which placed Resident 1 at significant risk, particularly given the resident's cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017763	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA MEADOWS DEFOREST	504 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 426	Continued From page 4 impairments and environmental conditions.	N 426		