

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Serenity Spring Senior Living at Scandia Village		STREET ADDRESS, CITY, STATE, ZIP CODE 10560 Applewood Rd Sister Bay, WI 54234	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when they did not ensure an allegation of misappropriation was reported to the State Agency (SA) or local police for 1 resident (R) (R14) of 1 sampled resident. R14's wallet went missing after 4/15/26. The facility did not report the allegation of misappropriation to the SA or local police. Findings include: The facility's Abuse, Neglect, Exploitation, and Misappropriation Policy, revised April 2021, indicates: Residents have the right to be free from .misappropriation of resident property .the facility will implement policies and protocols to prevent and identify .theft, exploitation, or misappropriation of resident property .identify and investigate all possible incidents of .misappropriation of resident property .investigate and report any allegations within the timeframes required by federal requirements. R14 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, insomnia, and history of stroke. R14's Minimum Data Set (MDS) assessment, dated 4/14/26, stated R14 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. On 6/3/26 at 9:38 AM, Surveyor asked Certified Nursing Assistant (CNA)-D if any residents were missing a wallet. CNA-D indicated R14's wallet was missing a few weeks ago. CNA-D was not sure if the wallet was found. On 6/3/26 at 9:45 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who heard R14 was missing a wallet with money. LPN-E stated R14 misplaced things but staff always found them. LPN-E was not sure if R14's wallet was found. On 6/3/26 at 10:07 AM, Surveyor interviewed Staffing Coordinator (SC)-F who indicated R14's wallet was reported missing to Social Services Director (SSD)-C a few weeks ago by a CNA or housekeeper. SC-F regularly worked the floor and stated R14 misplaced things, however, staff always found the items in R14's room. When SC-F was told by SSD-C that R14's wallet was missing, SC-F went to R14's room to search for the wallet. On 6/3/26 at 10:27 AM, Surveyor interviewed SSD-C who indicated a staff member reported that R14's wallet was missing. SSD-C asked R14 to describe the wallet and if there was any money in it. SSD-C stated R14 indicated there was between \$100 and \$900 in the wallet. SSD-C asked if R14 wanted to file a grievance but R14 declined. SSD-C indicated the allegation of misappropriation was not reported to the SA or the local police. On 6/3/26 at 10:36 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who became aware of the missing wallet a couple weeks ago. NHA-A confirmed R14 often misplaced items. NHA-A indicated R14's missing wallet was not reported to the SA or local police because R14 did not allege theft, only that the wallet was missing. On 6/3/26 at 1:19 PM, Surveyor interviewed R14 regarding the missing wallet. R14 verified the wallet was missing and contained \$900 which was now gone. R14 believed the money was stolen. On 6/3/26 at 1:22 PM, Surveyor interviewed Personal Care Worker (PCW)-G who visited R14 every week to assist with errands and appointments. PCW-G stated they brought R14 to the bank on 4/15/26 to withdraw \$1000. PCW-G indicated R14 liked to stash things but always put items in the same few spots. On 6/3/26 at 1:25 PM, PCW-G located R14's wallet in a dresser drawer. Surveyor observed a receipt in the wallet from a local bank for a (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	withdrawal of \$1000. Surveyor did not observe any money in the wallet or in the dresser drawer. R14 verified it was R14's wallet and the money was missing.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure an allegation of misappropriation was thoroughly investigated for 1 resident (R) (R14) of 1 sampled resident. R14's wallet went missing after 4/15/26. The facility did not thoroughly investigate the allegation of misappropriation or report the findings to the State Agency (SA). Findings include: The facility's Abuse, Neglect, Exploitation, and Misappropriation Policy, revised April 2021, indicates: Residents have the right to be free from .misappropriation of resident property .the facility will implement policies and protocols to prevent and identify .theft, exploitation, or misappropriation of resident property .identify and investigate all possible incidents of .misappropriation of resident property .investigate and report any allegations within the timeframes required by federal requirements. R14 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, insomnia, and history of stroke. R14's Minimum Data Set (MDS) assessment, dated 4/14/26, stated R14 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. On 6/3/26 at 9:38 AM, Surveyor asked Certified Nursing Assistant (CNA)-D if any residents were missing a wallet. CNA-D indicated CNA-D heard R14 was missing a wallet a few weeks ago. CNA-D was not sure if the wallet was found. On 6/3/26 at 9:45 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who confirmed they heard R14 was missing a wallet with money. LPN-E stated R14 sometimes misplaced things but staff always find them. LPN-E was not sure if R14's wallet was found. On 6/3/26 at 10:07 AM, Surveyor interviewed Staffing Coordinator (SC)-F who indicated R14's wallet was reported missing to Social Services Director (SSD)-C a few weeks ago by a CNA or housekeeper. SC-F regularly worked with R14 and stated R14 misplaced things often, however, the items were always found in R14's room. When SC-F was told by SSD-C that R14's wallet was missing, SC-F went to R14's room to search for the wallet. On 6/3/26 at 10:27 AM, Surveyor interviewed SSD-C who indicated a staff member reported that R14's wallet was missing. SSD-C asked R14 to describe the wallet and if there was any money in it. SSD-C stated R14 indicated the wallet contained between \$100 and \$900. SSD-C asked if R14 wanted to file a grievance, however, R14 declined. SSD-C did not have documentation to show evidence of an investigation. On 6/3/26 at 10:36 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated they became aware of R14's missing wallet a couple weeks ago and was aware that R14 often misplaced items. NHA-A indicated any documentation/investigation was SSD-C's responsibility. On 6/3/26 at 1:19 PM, Surveyor interviewed R14 who verified the wallet was missing and contained \$900 which was now gone. R14 believed the money was stolen. On 6/3/26 at 1:22 PM, Surveyor interviewed Personal Care Worker (PCW)-G who visited R14 every week to assist with errands and appointments. PCW-G stated they brought R14 to the bank on 4/15/26 to withdraw \$1000. PCW-G indicated R14 liked to stash things but always put things in the same few spots. On 6/3/26 at 1:25 PM, PCW-G found R14's wallet in a dresser drawer. Surveyor observed a receipt in the wallet from a local bank for a withdrawal of \$1000. Surveyor did not observe any money in the wallet or dresser drawer. R14 verified the wallet was R14's and the money was missing.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure proper discharge procedures and/or a written transfer or bed hold notice was provided to 3 residents (R) (R43, R8, and R41) of 3 sampled residents. R43 discharged from the facility on 4/10/25. R43's medical record did not contain a recapitulation of stay, confirmation of discharge against medical advice (AMA), indicate discharge orders were received from R43's primary care physician, or indicate education and further services were offered prior to discharge. R8 was transferred to the hospital on 2/23/26 and 4/29/26. R8's medical record did not contain written transfer or bed hold notices. R41 was transferred to the hospital on 4/5/26. R41's medical record did not contain a written transfer or bed hold notice. Findings include: The facility's policy Bed-Holds and Return policy, revised January 2026, indicates: .All residents/representatives are provided with written information regarding facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice. Notice 1: Well in advance of any transfer (e.g., in the admission packet); and Notice 2: At the time of transfer (or, if the transfer was an emergency, within 24 hours) .Multiple attempts to provide the resident representative with notice 2 should be documented in cases where staff are unable to reach and notify the representative timely. Written bed-hold notices provided to residents/representatives explain in detail: The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; the reserve bed payment policy as indicated by the state plan (for Medicaid residents); the facility policy regarding bed-hold periods; the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and the facility's return policy, the requirement that residents be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of payer source . The facility's Discharge Summary policy, revised January 2026, indicates: The discharge summary includes a recapitulation of the resident's stay and a final summary of the resident's status at the time of the discharge .Every resident is evaluated for his/her discharge needs and has an individualized post-discharge plan. The post-discharge plan is developed by the care planning/Interdisciplinary Team (IDT) with the assistance of the resident and his/her family and includes: where the individual plans to reside; arrangements that have been made for follow-up care and services; a description of the resident's stated discharge goals; the degree of caregiver/support person availability, capacity, and capability to perform required care; how the IDT will support the resident or representative in the transition to post-discharge care; what factors may make the resident vulnerable to preventable readmission; and how those factors will be addressed . 1. R43 was admitted to the facility on [DATE] for rehabilitation and had diagnoses including sepsis, gross hematuria, and congestive heart failure. R43's Minimum Data Set (MDS) assessment, dated 4/21/26, stated R43 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R43 was their own decision maker. R43's medical record indicated R43 discharged from the facility on 4/10/25. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 4/10/26, indicated R43 left the facility AMA at 5:30PM with their belongings. R43's medical record did not contain a recapitulation of stay, services offered prior to discharge, confirmation if R43 was discharged AMA, if discharge orders were received from primary care physician (PCP)-O, or if education was offered prior to discharge. On 6/3/26 at 10:01 AM, Surveyor interviewed Hospital Social Worker (HSW)-N who indicated PCP-O sent orders for R43 to be seen at the emergency room (ER) on 4/9/26 because R43 had shortness of breath and an oxygen saturation level of 87%, however, R43 did not go to the ER. HSW-N indicated there was concern when R43 did not go to the ER and PCP-O's office contacted the facility for follow-up. HSW-N indicated R43's medical record at the physician's office indicated the facility informed PCP-O's office on 4/17/26 that R43 left the facility, however, the facility did not know what day R43 left and thought R43 left AMA. HSW-N indicated R43's medical record at the physician's office did not contain an order from PCP-O to discharge R43 from the facility. Surveyor requested R43's medical record from PCP-O's office. On 6/3/26 at 11:46 AM, Surveyor interviewed Social Services Director (SSD)-C who indicated R43 was admitted to the facility on [DATE] from the hospital for rehabilitation. SSD-C was not working the day R43 left and recalled being told the discharge was a really weird situation and R43 indicated they were leaving the facility, R43 indicated to nursing staff that R43 did not need to be at the facility. Licensed Practical Nurse (LPN)-M obtained discharge orders from PCP-O. A discharge progress note was entered which indicated R43 left AMA. SSD-C indicated if a resident leaves AMA, the facility has the resident sign AMA paperwork. SSD-C confirmed R43's medical record did not contain signed AMA paperwork or signed discharge orders. On 6/3/26 at 11:59 AM, Surveyor interviewed LPN-M who called PCP-O's office and received a telephone order to discharge R43 from the facility on 4/10/26 otherwise R43 was going to leave the facility AMA. LPN-M indicated R43 was homesick and was visiting with family at the facility when R43 stated R43 no longer needed to be at the facility and requested family take them home. LPN-M showed Surveyor an order in R43's medical record, dated 4/10/26 and entered 4/13/26, from PCP-O to discharge R43 from the facility. LPN-M was not sure why the order was dated 4/10/26 but was entered on 4/13/26. LPN-M verified the order was a phone order and there was not a signed discharge order in R43's medical record. On 6/3/26 at 1:30 PM, Surveyor reviewed R43's medical record from Hospital (HSP)-Y and noted the following: ~ A summary note, dated 4/9/26, indicated PCP-O's office received a call from the facility at 11:10 AM that R43 was short of breath and had a low oxygen (O2) saturation level of 87%. PCP-O gave an order for R43 to be seen in the ER. The order was hand-delivered to Former Director of Nursing (FDON)-P. ~ Phone log documentation from PCP-O's office indicated PCP-O called the facility on 4/17/26 to follow-up on why R43 did not go to the ER. PCP-O's office phone log indicated the facility stated R43 left AMA but were unsure when R43 left. PCP-O's office called R43 at home. R43 stated they left the facility on 4/9/26. On 6/3/26 at 3:26 PM, Surveyor interviewed FDON-P who indicated R43 experienced shortness of breath and a low O2 saturation level on 4/9/26 and refused to be seen in the ER. FDON-P indicated R43 was visiting with family the next day and indicated R43 was leaving the facility and did not need (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be there for care. FDON-P indicated LPN-M received a phone order from PCP-O to discharge R43. FDON-P indicated R43 indicated they were going to leave AMA prior to LPN-M receiving phone order. FDON-P indicated a phone order was received for discharge and PCP-O was updated at that time. FDON-P was unsure what documentation or discharge processes were conducted following the phone order for discharge. 2. R8 had diagnoses including gastrointestinal bleeding and cellulitis. R8's MDS assessment, dated 5/28/26, stated R8 had a BIMS score of 15 out of 15, indicating intact cognition. R8 was their own decision maker. R8's medical record indicated R8 was transferred to the hospital on 2/23/26 for concerns of abnormal vital signs post-fall and possible gastrointestinal bleeding. R8 was also transferred to the hospital on 4/29/26 for chest pain. R8's medical record did not contain a written transfer or bed-hold notice for either transfer. On 6/3/26, Surveyor requested a copy of R8's written transfer and bed-hold notices for 2/23/26 and 4/29/26 from Nursing Home Administrator (NHA)-A. On 6/3/26 at 9:54 AM, NHA-A confirmed R8 was not provided a written transfer or bed-hold notice for the hospital transfers on 2/23/26 and 4/29/26. 3. R41 was admitted to the facility on [DATE] and had diagnoses including heart disease, atrial fibrillation, panic disorder, and post-traumatic stress disorder (PTSD). R41's MDS assessment, dated 1/25/26, stated R41 had a BIMS score of 15 out of 15, indicating intact cognition. R41 was their own decision maker. R41's medical record indicated R41 was transferred to the hospital on 4/5/26. A progress note, dated 4/7/26, indicated R41 was admitted to the hospital. R41's medical record did not contain a written transfer or bed-hold notice for the hospital transfer. On 6/3/26 at 1:32 PM, Surveyor interviewed NHA-A who indicated NHA-A could not provide written transfer or bed hold notices for R43, R8, or R41. NHA-A recognized there was a process concern with transfers/discharges and stated NHA-A would educate staff on the proper procedure.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R23 and R3) of 4 sampled residents received the necessary care and services to promote healing and/or prevent pressure injuries from worsening. R23 was seen in the wound clinic on 5/28/26 for right dorsal foot, left fifth dorsal toe, and right hallux bunion wounds. New treatments were ordered. The facility was not aware of the updated orders which resulted in a missed dressing change for R23's right dorsal foot on 5/31/26. R3 had a stage 4 pressure injury on the left heel and an order for a dressing change every other day. R3's Treatment Administration Record (TAR) indicated the dressing change was not completed on 5/20/26. Findings include: The facility's Wound Care policy, revised January 2026, indicates: The purpose of the policy is to provide guidelines for the care of wounds to promote healing. Documentation: The following information should be recorded in the resident's medical record: .2. The date and time wound care was given .1. R23 was admitted to the facility on [DATE] and had diagnoses including pressure ulcers to calf and foot, malignant neoplasm of sigmoid colon, and protein calorie malnutrition. R23's Minimum Data Set (MDS) assessment, dated 3/17/26, stated R23 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R23's medical record contained the following wound care orders:~ Ensure wound dressings are clean, dry, and intact. Every shift for wound care (dated 4/28/26)~ Wound Care: (Right) Dorsal Foot: Remove dressing down to the Mepilex Transfer, but DO NOT remove the white Mepilex Transfer foam as R23 has Grafix underneath. Reapply the outer dressing including part of an ABD pad held in place with a few turns of Kerlix. Change just the outer portion of the dressing on Tuesday, Thursday, and Sunday once daily every Tuesday, Thursday, Sunday for wound care (dated 5/21/26)~ Wound Care: Left Hallux Bunion: Cleanse with saline, pat dry. Paint with Betadine and keep covered with protective Band-Aids changed every 2 days. Every day shift every other day for wound care (dated 5/21/26)~ Wound Care: Left Hallux Bunion: Cleanse with saline, pat dry. Paint with Betadine and keep covered with protective Band-Aids changed every 2 days. Every 24 hours as needed for wound care (dated 5/21/26 On 6/2/26 at 10:28 AM, Surveyor observed Registered Nurse (RN)-X provide wound care for R23's left hallux bunion wound with observation/instruction from RN-T. During wound care, R23 indicated to RN-X that at R23's last appointment at the wound clinic on 5/28/26, the provider changed the orders for the right dorsal foot. RN-T indicated the facility would call the provider for updated orders. On 6/2/26, Surveyor reviewed orders written by the wound clinic following R23's appointment on 5/28/26 which indicated the following:~ (R23) to wear heel raiser/heel protector boot to right foot at all times, except showering. Check skin surrounding area twice daily. Two times a day for wound care. (Of note: The order was dated 5/28/26 and transcribed 6/2/26.)~ Wound Care: Right Dorsal Foot: Remove dressing and cleanse with Vashe or normal saline. May perform a dry gauze rub to remove any superficial slough/bioburden. Cover the open area with UrgoClean AG then cover with an ABD pad held in place with a few turns of Kerlix. R23 may continue to use foam heel pads placed beneath the Tubigrip as before. Change 3 times per week (once in the wound clinic on Thursdays). One time a day every Tuesday and Sunday. (Of note: The order was dated 5/28/26 and transcribed 6/2/26.)~ (R23) to plan for surgery on 6/19/26. Podiatry will call 2 days prior with the time of surgery. (Of note: The order was dated 5/28/26 and transcribed 6/2/26.) On 6/2/26, Surveyor reviewed R23's Medication Administration Record (MAR)/TAR and noted a missed dressing change for the right dorsal foot on 5/31/26. On 6/3/26 at 11:33 AM, Surveyor interviewed Director of Nursing (DON)-B who verified the updated orders were not obtained after R23's wound clinic appointment on 5/28/26 which resulted in a missed treatment on 5/31/26. 2. R3 was admitted to the facility on [DATE] and had a diagnosis of pressure ulcer to left heel. R3's MDS assessment, dated 3/27/26, stated R3 had a BIMS score of 15 out of 15, indicating intact cognition. R3's medical record contained the following order: ~ Left Heel: Remove dressing. Cleanse with Vashe (may substitute saline if (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vashe is not available). May perform a dry gauze rub to remove any superficial slough. May apply emollient cream (dated 5/13/26) On 6/3/26, Surveyor reviewed R3's TAR and noted wound care was not completed on 5/20/26. On 6/3/26 at 1:17 PM, Surveyor interviewed DON-B who verified R3's wound treatment was not documented as completed on 5/20/26. DON-B indicated staff should complete wound treatments and document completion.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff, resident, representative interview, and record review, the facility did not ensure the resident environment was as free of accident hazards as possible for 2 residents (R) (R10 and R15) of 3 sampled residents. In addition, the facility did not ensure 2 residents (R6 and R18) of 2 sampled residents had behavioral interventions and were adequately supervised. R10 had a fall with injury on 4/24/26. The facility did not update R10's care plan post-fall. R15 had a fall with injury on 6/2/26. The facility did not complete post-fall assessments, provide prompt or appropriate medical care, implement falls interventions, or notify the required parties. R6 and R18 were known to wander into other residents' rooms uninvited. R6 and R18's care plans did not contain interventions to address wandering or appropriate levels of supervision. Findings include: The facility's Care Planning-Interdisciplinary Team policy, revised January 2026, indicates: The Interdisciplinary Team (IDT) is responsible for the development of resident care plans. Comprehensive, person-centered care plans are based on resident assessments and developed by the IDT. The IDT includes but is not limited to: the resident's attending physician; a registered nurse with responsibility for the resident; a nursing assistant with responsibility for the resident; a member of the food and nutrition services staff; to the extent practicable, the resident and/or the resident's representative; and other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. The resident, the resident's family, and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. The facility's Goals and Objectives, Care Plans policy, revised January 2026, indicates: Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Care plans will be modified accordingly. Care plan goals and objectives are .resident oriented; behaviorally stated and measurable; and contain timetables to meet the resident's needs. Goals and objectives are reviewed and/or revised: when there has been a significant change in the resident's condition; when the desired outcome has not been achieved; when the resident has been readmitted to the facility from a hospital/ rehabilitation stay; and at least quarterly. The facility's Assessing Falls and Their Causes policy, revised January 2026, indicates: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Review the resident's care plan to assess any special needs of the resident. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly. After a fall: If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. Obtain and record vital signs as soon as it is safe to do so. Notify the resident's attending physician and family in an appropriate time frame. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, notify the practitioner routinely (e.g., by fax or by phone the next office day). Observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and document findings in the medical record. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Complete an incident report for resident falls no later than 24 hours after the fall. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. and/or whether there is a pattern of falls for this resident. When a resident falls, the following information should be recorded in the resident's medical record: The condition in which the resident was found; assessment data, including vital signs and any obvious injuries; interventions, first aid, or treatment administered. Completion of a falls risk assessment. Appropriate interventions taken to prevent future falls. 1. R10 had diagnoses including Alzheimer's disease, dementia, and repeated falls. R10's Minimum Data Set (MDS) assessment, dated 3/22/26, stated R10 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Serenity Spring Senior Living at Scandia Village		STREET ADDRESS, CITY, STATE, ZIP CODE 10560 Applewood Rd Sister Bay, WI 54234	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severely impaired cognition. R10 had an activated Power of Attorney (POA). A care plan, revised 3/27/26, indicated R10 was at high risk for falls related to immobility, history of falls, dizziness, and giddiness. The last intervention added to the care plan indicated the blinds should be closed when dark outside and open when light outside (dated 11/4/25). A progress note, dated 4/24/26, indicated staff found R10 found face down on the floor of the bathroom with a bedside toilet seat caught in R10's brief and pajamas. R10 was bleeding from a gash on the left side of the forehead. R10's left eye was swollen and bruised and R10 had skin tears to both elbows. The bed alarm did not sound but was in place and working properly. Immediate interventions were to encourage R10 to use the call light for assistance and ensure the bed alarm was functioning properly. (Of note: There were no fall interventions added after R10's care plan following the fall.) A fall report, dated 4/24/26, contained the same information as the progress note above and also indicated an assessment was completed, 911 was called, and R10 was sent to the Emergency Department (ED). Injuries reported post incident - none identified. Predisposing environmental factors - none identified. Predisposing physiological factors identified were confusion, gait imbalance, impaired memory, and incontinence. Predisposing situation factors were identified as a walker. Other information indicated R10's wheelchair was in front of the bed and walker was in front of the sink in the bathroom. A Hospital After Visit Summary, dated 4/24/26, indicated R10 had a laceration on the left forehead, skin tears on the forearm and upper left arm, a hemorrhage on the inside of the eye, and a contusion on the face. On 6/1/26 at 12:09 PM, Surveyor observed R10 in the dining room with a bandage on the left side of their forehead. On 6/1/26 at 12:38 PM, Surveyor interviewed Power of Attorney (POA)-R who expressed concern that a bed alarm did not sound when R10 got out of bed and fell. POA-R indicated R10 might have gotten up to use the bathroom and required assistance with ambulation. POA-R indicated R10's facial injuries were extensive and R10 was heavily bruised. POA-R did not know what the facility was doing to prevent future falls or injury. POA-R indicated staff tested R10's bed alarm and stated it was functioning properly. On 6/3/26 at 10:34 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated falls are reviewed by the IDT and interventions are reviewed and revised in a residents's care plan following a fall. DON-B confirmed a fall intervention was not added to R10's care plan following the fall on 4/24/26. 2. R15 had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, difficulty walking, and delirium due to known physiological condition. R15's MDS assessment, dated 4/23/26, stated R15 had a BIMS score of 6 out of 15, indicating severely impaired cognition. R15 had an activated POA. A care plan, dated 7/22/25, indicated R15 was at high risk for falls related to delirium and forgetfulness and right-sided weakness from cerebral infarction (stroke). The care plan contained interventions to follow the facility's fall protocol, review information on past falls and attempt to determine cause of falls, record possible root causes, and alter or remove potential causes if possible. The care plan indicated R15 had chair and bed alarms and staff should ensure they were in place and working correctly. On 6/2/26 at approximately 7:45 AM, Surveyor observed Certified Nursing Assistant (CNA)-Q push R15 in a wheelchair down the hallway. CNA-Q informed Registered Nurse (RN)-V that R15 required RN-V's attention. Surveyor observed RN-V provide wound care for R15's left arm and elbow. Surveyor interviewed R15 who stated, I slipped. After completing wound care, RN-V left R15 without further assessment to continue with medication pass. On 6/2/26 at 1:11 PM, Surveyor interviewed POA-S who expressed concern related to follow-up for R15's fall on the morning of 6/2/26. POA-S arrived at the facility at 10:40 AM and observed R15 at the nurses' station with a bandage on the left forearm. When POA-S asked what occurred, RN-V stated R15 must have bumped it. POA-S indicated RN-V just brushed it off. POA-S stated RN-T completed wound care for R15's left forearm and assessed R15. RN-T observed rug burn on R15's left knee and applied a bandage. POA-S indicated R15 could not accurately report what occurred due to cognitive deficit. POA-S attended an activity with R15 during which an activity aide told POA-S that R15 fell before breakfast. POA-S asked Regional Registered Nurse (RRN)-U about the fall. RRN-U (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated R15 fell near the front entrance of the facility and had likely gotten up and continued to walk to the dining area for breakfast. CNA-Q found R15 and informed RN-V that R15 needed assistance. There was blood on R15's arm and knee and a trail of blood from the dining area to the front entrance. POA-S was frustrated that the fall was not addressed properly and R15 did not receive adequate care following the fall. POA-S indicated R15's forearm and knee were not addressed until POA-S arrived hours later and noted the injuries. POA-S was also frustrated that RN-V did not tell POA-S the truth right away. On 6/3/26, Surveyor reviewed R15's medical record which did not contain a fall report, assessment, investigation, or neurological assessments for the unwitnessed fall that occurred on 6/2/26. Surveyor noted two progress notes, dated 6/2/26 and written by RN-T, that indicated R15's wounds were assessed and dressed and a progress note that indicated POA-S would speak with DON-B regarding the injuries. On 6/3/26 at 10:34 AM, Surveyor interviewed DON-B who indicated administration discussed the fall and concluded RN-V did not look into the fall or handle the fall correctly per policy. DON-B verified there was not a fall investigation, appropriate wound care, or notification. DON-B indicated a grievance was filed immediately for POA-S regarding notification of fall with injuries. On 6/3/26 at 1:31 PM, Surveyor interviewed CNA-Q who discovered R15 in the dining room with blood on the left arm and observed a trail of blood from R15 to the hallway. CNA-Q indicated R15 stated they had fallen. CNA-Q assisted R15 to their bedroom and informed RN-V that R15 had fallen and needed assistance. CNA-Q also informed Licensed Practical Nurse (LPN)-M and Social Services Director (SSD)-C of the incident. CNA-Q indicated LPN-M and SSD-C stated they believed that was where the blood by the front door came from. CNA-Q indicated R15 would have been able to get off the floor independently and stated if staff had noticed R15 on the floor, they would have provided assistance immediately. On 6/3/26 at 1:45 PM, Surveyor interviewed Regional Director of Clinical Services (RDCS)-W verified staff did not follow the facility's fall protocol for R10 and R15. 3. On 6/1/26 at 10:47 AM, Surveyor interviewed R38 who expressed concern that R6 frequently entered R38's room uninvited. R38 stated R6 entered their room at 12:30 AM that morning (6/1/26), turned on the light while R38 was sleeping, and stated the room belonged to R6. R38 indicated R6 entered their room approximately five times last week, including once in the middle of the night, and stated it was R6's daughter's room and R6 needed to get her up. R38 indicated R6 threatened to call the police on R38 last week and in another incident indicated they needed to use R38's bathroom. R38 tried to redirect R6 to their room next door to use their own bathroom. R38 stated R6 used R38's bathroom instead and urinated all over the toilet and floor. R38 indicated their sleep is disrupted at night and they are in a private room and should have privacy. R38 stated staff remove R6 from the room, however, the incidents continue to occur and R38's privacy and personal space is not respected. (Of note: R38's MDS assessment, dated 5/14/26, indicated R38 had intact cognition.) R6's medical record indicated R6 had diagnoses including dementia, insomnia, and unspecified mood disorder. R6's MDS assessment, dated 5/20/26, stated R6 had a BIMS score of 14 out of 15, indicating intact cognition. A care plan, revised 2/3/25, indicated R6 had behavior problems, refused assistance, and did not use a call light appropriately due to dementia and poor safety awareness. The care plan indicated R6 liked to wander the facility freely and had a WanderGuard on the left ankle (initiated 2/19/25). The care plan contained an intervention to monitor behavior episodes and attempt to determine underlying cause. consider location, time of day, persons involved, and situations and document behavior and potential causes. A progress note, dated 5/17/26, indicated R6 had visual hallucinations, periods of anger and harm to others with a walker, and many attempts to exit the building. Surveyor did not observe any progress notes that indicated R6 wandered into others' rooms and required redirection or that the IDT discussed behavioral interventions and/or care plan updates/interventions for behavioral concerns and wandering. During a Resident Council meeting at 1:00 PM on 6/2/26, R7 expressed concern that R6 entered their room uninvited. R7 indicated it happened at least three times and they changed rooms due to the disturbances. (Of note: R7's MDS assessment, dated 5/6/26, indicated R7 had moderately impaired cognition.) On 6/2/26 at 1:21 PM, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor interviewed CNA-Q who stated R6 pulls clothing out of their closet during the day and requires assistance with putting the clothing back in. CNA-Q indicated R6's behavioral concerns have increased during the evening and night hours, including entering other residents' rooms uninvited. CNA-Q indicated R18 enters other residents' rooms all the time and there really isn't much we can do. CNA-Q indicated when R6 enters other residents' rooms, staff redirect R6. CNA-Q was not aware of any other interventions to prevent the behavior. (See additional interview under example 4.) 4. On 6/2/26, Surveyor reviewed the facility's grievance file and noted R33 submitted a grievance on 4/1/26 that indicated R33 was asleep in a dark room and awoke to find (R18) standing in the room with what appeared to be a candy wrapper in their hand. R33 yelled for (R18) to get out of room. (R18) began to leave and then came back. R33 activated the call light for assistance and again told (R18) to leave. (R18) left the room prior to staff arriving. The grievance form indicated R18 entered another resident's room the day prior (3/31/26). The resolution indicated staff would continue to redirect R18 from entering others' rooms and the facility would look into stop signs to prevent residents from entering other residents' rooms. The date completed was 4/25/26. R18's medical record indicated R18 had diagnoses including frontotemporal neurocognitive disorder (umbrella term for a group of progressive brain diseases that damage the frontal and temporal lobes, affecting personality, behavior, language, and sometimes movement) and panic attacks. R18's MDS assessment, dated 5/7/26, stated R18 had a BIMS score of 2 out of 15, indicating severely impaired cognition. A care plan, revised 11/26/25, indicated R18 was an elopement/wander risk and had a history of putting themselves in other residents' rooms/beds when wandering (dated 9/21/25). The care plan contained an intervention to identify pattern of wandering and intervene as appropriate (dated 8/1/25). On 6/2/26 at 10:10 AM, Surveyor interviewed R33 who indicated they submitted a formal grievance due to R18 entering their room. R33 recalled the incident and stated it scared me. R33 stated the incident occurred in the early morning while it was still dark and R33 awoke to find R18 standing over them and staring at them with a candy wrapper in hand. R33 shouted twice at R18 to get out of the room, however, R18 left and came back. R33 used the call light the second time when R18 didn't leave but stated R18 eventually left before staff arrived. R33 indicated R18 frequently enters others' rooms uninvited. R33 stated staff are aware and redirect R18, however, nothing is done to prevent it. R33 stated R18 is calm and quiet during the day, roams the halls, and does not enter others' rooms until late afternoon or later. R33 indicated R18 chases people around. R33 thought R18 followed R33 in common areas of the facility after the incident which frightened R33 to the point that R33 does not like to come out of R33's room at all due to feeling watched and pursued by R18. R33 indicated staff told them R18 has a mind of a child and is harmless. R33 stated the incidents have made them more secluded and they do not feel safe to freely move about the facility. R33 indicated there aren't stop signs on doors or other deterrents to keep others from entering rooms aside from staff redirection. R33 indicated the incident felt like an invasion of my privacy. R33 stated the incidents are not handled appropriately and R33 was told R18 had a right to move freely in the facility and outside of R18's room. R33 stated they have a right to feel safe in their home which they feel is not being considered. R33 stated the facility should do something before something bad happens to someone. (Of note: R33's MDS assessment, dated 3/19/26, indicated R33 had moderately impaired cognition.) During a Resident Council meeting at 1:00 PM on 6/2/26, R23 stated R18 is constantly in and out of my room. R23 state it is scary and indicated residents who wander were previously on a secured unit and did not have access to other units without assistance. (Of note: R23's MDS assessment, dated 5/28/26, indicated R23 had intact cognition.) On 6/3/26 at 10:05 AM, Surveyor conducted an abbreviated tour of the facility and did not observe stop signs on residents' doors or in hallways. On 6/3/26 at 10:34 AM, Surveyor interviewed DON-B who was not aware R6 and R18 frequently entered other residents' rooms which was a concern for other residents. DON-B indicated concerns are addressed in IDT meetings and interventions are discussed and implemented. DON-B reviewed R6 and R18's care plans and confirmed they did not contain updated interventions for supervision or to assist in the prevention (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of entering other residents' rooms. DON-B indicated the grievance form filled out by R33 would need follow-up by the IDT. DON-B indicated if the incident occurred, the resolution should be in R33's care plan and R18's behavior should be monitored through behavioral tracking which was not occurring for R6 or R18. DON-B stated DON-B would investigate further to find updated care plan interventions and IDT notes. (Of note: Surveyor did not receive updated care plan interventions or IDT notes for R6 or R18.)		