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
	0016336	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA MC	**795 TARRAGON DRIVE KAUKAUNA, WI 54130**

(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 10/20/2023, Surveyor conducted 2 complaint investigations at Landings of Kaukauna MC. One deficiency was identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 22	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. 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 Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the Department within 3 working days after law enforcement personnel was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of resident or employees. Resident 1 called police after allegedly sitting in his/her chair for 2-4 hours without help. Findings include:	N 164		

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
	0016336	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA MC	795 TARRAGON DRIVE KAUKAUNA, WI 54130

(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 164	Continued From page 1 On 07/11/2023, the Department received a complaint alleging concerns with resident cares. On 10/20/2023, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted on 02/06/2023 with diagnosis including type 2 diabetes, Bipolar disorder, anxiety, post-traumatic stress disorder, and Alzheimer's. Resident 1 was their own legal decision maker. Resident 1 discharged from the facility on 07/11/2023. Kaukauna Police Department incident K23001858 dated 02/21/2023 documented: "On the above date and time, I [Officer B] was dispatched to the provider for a welfare check. The Outagamie County Communication Center advised that [Resident 1] had called from the provider reporting [s/he] had been sitting in a chair in [his/her] waste for 2-4 hours and has been pushing [his/her] call button several times; however, no staff has responded. Upon arrival at the facility, I [Officer B] rang the doorbell to the secured facility ....The [fe/male] opened the door and allowed us inside. The [fe/male] was identified as [Caregiver C] and stated [s/he] was the only staff member for the facility. We explained to [Caregiver C] the call we had received and [s/he] immediately stated that their pager system had not been working properly and that [s/he] had no alerts on [his/her] pager, which [s/he] did show officers. I [Officer B] asked [Caregiver C] to lead us to [Resident 1's] room. [Caregiver C] did so and upon arrival we located [Resident 1] sitting in a recliner. [Resident 1] was immediately upset and bean repeating that [s/he] had been pushing	N 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016336	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA MC	795 TARRAGON DRIVE KAUKAUNA, WI 54130

(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 164	Continued From page 2 [his/her] pendant and no one had come to help [him/her]. We explained to [Resident 1] it appeared the pager system was not working. While in the room, officers tested [Resident 1's] pendant and [Caregiver C's] pager was not receiving the alert. [Resident 1] stated that [s/he] has brought this concern to the lead nurse of the facility who stated that staff was to provide [him/her] with a new pendant. [Caregiver C] stated [s/he] was unaware where any new pendants were and could not assist in the matter. I [Officer B] asked [Caregiver C] if [s/he] could provide me with information for the manager of the facility. Once [Caregiver C] stepped out of the room, I [Officer B] informed [Resident 1] I [Officer B] understood [his/her] concern this evening and agreed it was not acceptable .... Prior to leaving the facility, I [Officer B] asked [Caregiver C] if they could check on [Resident 1] more frequently this evening until the pendant could be fixed." On 10/20/2023, Surveyor reviewed Department records. There were no self-reports in the Department files regarding the above incident. On 10/20/2023 at 10:50 AM, Surveyor interviewed Administrator A. Administrator A stated when a state reportable incident occurs s/he sends the required information to the regional director for review, and they submit the report if needed. Administrator A stated after speaking to his/her regional director they did not think the above incident was a reportable incident, since Resident 1 called the police him/herself. Surveyor reviewed the code requirement with Administrator A. Administrator A noted the above incident should have been	N 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016336	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA MC	**795 TARRAGON DRIVE KAUKAUNA, WI 54130**

(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 164	Continued From page 3 reported to the Department.	N 164		