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
	0010166	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS SENIOR PARK	**77 WISCONSIN AMERICAN DR FOND DU LAC, WI 54935**

(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 08/12/2024 with additional information gathered through 08/15/2024, Surveyor conducted a complaint investigation at Woodlands Senior Park in Fond du Lac. As a result, the complaint is substantiated and 1 deficiency is identified. Census: 22	N 000		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure sufficient staff were provided on a 24-hour basis to meet the needs of 22 residents. Two of 2 staff left the residents unattended during 3rd shift when they left the building to assist a staff in a sister facility. Findings include: On 08/05/2024, the Department received a complaint alleging the facility was left unattended. The provider is licensed to serve up to 30 residents who are advanced age, terminally ill and/or have irreversible dementia/Alzheimer's. There were 22 residents at the time of Surveyor's visit. On 08/12/2024, Surveyor entered the facility to conduct a complaint investigation. Surveyor requested the staff schedule for July 21 through July 27, 2024 from Administrator A. Surveyor	N 396		

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

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N 396	Continued From page 1 observed the staff schedule and noted 2 staff, Caregiver B and Caregiver C, were scheduled to work 3rd shift on 07/22/2024 from 11:00 PM to 7:00 AM. Surveyor observed Caregiver C's name was handwritten in on the schedule for 07/22/2024, 07/23/2024 and 07/24/2024 for the 11:00 PM to 7:00 AM shift. Administrator A stated s/he handwrote Caregiver C's name on the staffing schedule as s/he is no longer employed at the facility. Administrator A stated since Caregiver C is no longer employed his/her name will no longer show on the schedule. Administrator A also stated they typically only have one staff working 3rd shift unless they have a new staff that is being trained, then there are two staff. On 08/12/2024 at 10:47 AM, Surveyor interviewed Administrator A who stated s/he was not aware if Caregiver B and Caregiver C left the facility during their night shift on 07/22/2024 to assist at their sister facility. Administrator A reported, "Staff should not be going to other buildings to assist during an emergency." On 08/13/2024 at 7:42 PM, Surveyor interviewed Caregiver B via phone who reported in the early morning on 07/23/2024 a caregiver from their sister facility called asking if s/he or Caregiver C could come assist with a resident fall. Caregiver B reported s/he was training Caregiver C at the time and thought it would be a good training opportunity. Caregiver B stated s/he and Caregiver C left the facility and walked across the parking lot to the sister facility. Caregiver B reported Caregiver C was never in the sister facility before and it was his/her first night working. Caregiver B stated s/he walked Caregiver C into the facility and showed him/her where to go to assist the other caregiver.	N 396		

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N 396	Continued From page 2 Caregiver B reported, "I walked right back. I had cares to do. I was gone for 2 to 3 minutes. I know I'm not supposed to leave the building." On 08/14/2024 at 1:29 PM, Surveyor interviewed Caregiver C via phone who reported a resident fall happened in a sister facility on 07/23/2024. Caregiver C stated the caregiver from the sister facility reached out to Caregiver B because s/he needed assistance. Caregiver C stated it was his/her first day working and s/he was training with Caregiver B. Caregiver C reported they walked over to the sister facility around 5:00 AM to see what was going on. Caregiver C verified there were no other staff in the building when they left. Caregiver C reported Caregiver B was with him/her at the sister facility for about 5 minutes before s/he went back to the facility. On 08/15/2024 at 9:00 AM, Surveyor interviewed Administrator A via phone who again confirmed s/he was not aware staff left the facility unattended on 07/23/2024 to assist at their sister facility. Administrator A stated, "This is not our typical policy for staff to leave the facility. It was a unique situation that occurred." The provider did not ensure there was 24-hour supervision of the facility when staff left to assist a sister facility with a resident fall.	N 396		