

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0010166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/04/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODLANDS SENIOR PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>77 WISCONSIN AMERICAN DR FOND DU LAC, WI 54935</b>
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(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	<p>Initial Comments</p> <p>On 01/03/2024 with additional information gathered through 01/04/2024, Surveyor conducted a complaint investigation at Woodlands Senior Park in Fond du Lac. As a result, 2 of 2 complaints were unsubstantiated and no deficiencies were identified.</p> <p>Census: 21</p>	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE