

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018075	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/30/2026
NAME OF PROVIDER OR SUPPLIER WOLVERTON GLEN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 50 WOLVERTON AVENUE RIPON, WI 54971		
(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 07/30/2026, Surveyor conducted a standard survey and one (1) complaint investigation at Wolverton Glen Assisted Living. As a result of the survey 1 complaint was substantiated. Two deficiencies identified. Census: 16	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		
	This Rule is not met as evidenced by:			

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

TITLE

(X6) DATE

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N 239	<p>Continued From page 1</p> <p>Based on record review and interview, the provider did not ensure 1 of 1 employee obtained all department approved training as required.</p> <p>Caregiver B did not have training in fire safety within 90 days after starting employment.</p> <p>Caregiver B did not have training in first aid/choking within 90 days after starting employment.</p> <p>Findings include:</p> <p>On 07/30/2026 at 1:30 PM, Surveyor reviewed Caregiver B's employee record. Assisted Living Director (ALD) C stated Caregiver B has worked for about 2 years at the facility. Caregiver B was not on the staff roster, as s/he worked in a different area and filled in as needed. ALD C confirmed Caregiver B has worked in the community based residential facility (CBRF), and that Caregiver B was a CNA. The record contained no evidence of fire safety and first aid with choking for Caregiver B.</p> <p>On 07/30/2026 at 2:00 PM, Regional Director of Wellness (RDW) A confirmed Caregiver B was not on the registry for fire safety and first aid/choking. RDW A stated Caregiver B's last day of employment was on date of survey.</p> <p>On 07/30/2026 at 3:00 PM, Surveyor interviewed Caregiver B. Caregiver B stated s/he had worked for the facility for about 2 years. Caregiver B stated s/he was a CNA. Caregiver B was unaware what the CBRF required trainings were.</p> <p>The provider did not ensure caregivers received fire safety and first aid/choking training within 90 days after starting employment.</p>	N 239		

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N 239	Continued From page 2	N 239			
	Cross Reference: N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty and Awake				
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least one qualified resident care staff was present in the facility when one or more residents were present in the facility. Caregiver B was not a qualified resident care	N 397			

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N 397	<p>Continued From page 3</p> <p>staff, as s/he did not complete all required training, s/he worked alone in the facility, and left residents alone in the facility when s/he left his/her shift.</p> <p>Findings include:</p> <p>Wis. Admin. Code § DHS 83.02(42) states: "Qualified resident care staff means an employee who has successfully completed all of the applicable training and orientation under Subch. IV."</p> <p>The provider is licensed to care for 20 residents in the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, developmentally disabled, and/or terminally ill.</p> <p>On 03/25/2026, the bureau received a complaint alleging residents left unattended in the facility.</p> <p>On 07/30/2026 at 1:30 PM, Surveyor reviewed Caregiver B's record. Assisted Living Director (ALD) C acknowledged s/he had heard about Caregiver B leaving the building before his/her replacement had arrived. ALD C stated this incident happened right around the time s/he had started. ALD C confirmed s/he did not have all the information, however Regional Director of Wellness (RDW) A should be able to provide the information.</p> <p>On 07/30/2026 at 2:00 PM, Surveyor interviewed RDW A. RDW A stated s/he was unaware of this incident, but s/he would gather the information. RDW A provided Surveyor with an investigation summary for potential resident abandonment for 03/15/2026. The investigation confirmed Caregiver B was working on 03/15/2026 and had</p>	N 397		

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N 397	<p>Continued From page 4</p> <p>worked a double shift. At 10:00 PM, his/her replacement had not shown up, so approximately 10:15 PM, Caregiver B locked the keys in the med cart and left the facility. A resident went to the skilled facility attached to the community based residential facility and informed the director of nursing (DON) there was no staff in the building and residents were ringing. DON arranged coverage until Caregiver D was able to arrive at approximately 12:15 AM. On 03/17/2026, Caregiver B was questioned. Caregiver B stated "[s/he] believed sending a text message was sufficient communication as her supervisor didn't initially respond to his/her call but did text back." Caregiver B stated, "there was a snowstorm on Sunday, March 15th, and that [s/he] had worked a double shift and was unable to work beyond 16 hours." The investigation findings:</p> <ul style="list-style-type: none"> * Failure to follow the chain of communication when staffing concerns arose. * Failure to notify supervisory personnel that the scheduled NOC employee had not arrived. * Leaving the facility without confirming resident supervision and staff coverage. * Potential resident abandonment due to residents being left without staff present. * Failure to appropriately escalate an urgent staffing concern. <p>The investigation stated Education was provided. "[Caregiver B] was informed that leaving the facility without ensuring resident coverage constitutes abandonment and is a serious resident safety concern. Expectations regarding immediate notification of supervisory staff and appropriate escalation procedures for staffing emergencies were reviewed. [Caregiver B] was educated that text messaging alone is not an appropriate or sufficient method of</p>	N 397			

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N 397	<p>Continued From page 5</p> <p>communication in situations involving resident safety or staffing emergencies."</p> <p>On 07/30/2026 at 3:00 PM, Surveyor interviewed Caregiver B. Caregiver B confirmed s/he had worked a double in the facility on 03/15/2026. Caregiver B stated s/he had worked with another staff person who left around 7:00 PM. Caregiver B stated s/he worked alone from about 7:00 PM till 10:00 PM. Caregiver B stated s/he had tried to reach out to his/her supervisor, but s/he did not answer. Caregiver B stated s/he had started his/her car and waited in the building for a little bit and then Caregiver B stated s/he had to leave and a little after 10:00 PM, s/he left the facility, but the next shift had not shown up. Caregiver B stated s/he was interviewed by Administrator E, and that Administrator E had told him/her s/he could not leave without coverage in the building.</p> <p>On 07/30/2026 at 3:30 PM, Surveyor interviewed RDW A. RDW A stated they believed the facility was unsupervised for about 1 hour. Surveyor requested staff punches, however the DON sent someone from the skilled nursing to cover before staff arrived.</p> <p>The provider did not ensure there was a qualified resident care staff present in the facility when one or more residents were present in the facility.</p> <p>Cross Reference: N0239 DHS 83.20(2)(a)-(d) Department Approved Training Courses</p>	N 397		