STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525061	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Park Nursing and Rehab LLC	1700 C A Becker Dr Racine, WI 53406

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to maintain infection prevention practices during medication administration for six of six residents (Resident (R) 4, R5, R10, R11, R13, and R15) observed. Two nurses observed placed residents' medications and medical devices on surfaces without cleaning them, failed to clean shared equipment and failed to appropriately put on (don) and doff (remove) personal protective equipment. These deficient practices had the potential to place residents at risk for the spread of infection and cross-contamination and created a risk for an increased potential for infections compromising the health and safety of residents. Findings include:1. Review of R4's Face Sheet provided by the facility revealed R4 was admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis that included but not limited to diabetes mellitus due to underlying conditions with diabetic neuropathy. Review of R5's Face Sheet provided by the facility revealed that R5 was admitted to the facility on [DATE] with a diagnosis that included but not limited to heart failure and unspecified asthma.During an observation and interview on 10/01/25 at 4:52 PM, Licensed Practical Nurse (LPN) 1 performed vital checks and administered scheduled medications to R4 and R5 in their shared room. LPN1 performed vital checks i. e. blood pressure and pulse oximeters on R5. Once finished with R5, LPN1 performed vital checks for R4 and applied eye drops to both of R4's eyes. LPN1 failed to don and doff personal protective equipment (PPE) between providing care to the residents. LPN1 returned to the medication cart located in the hall adjacent to the room and attempted to discreetly return R4's white and grey glucometer (a device used to check blood sugar readings) to the medication cart. LPN1 stated staff are to wear gloves during care and perform and hygiene and sanitize the equipment between residents. LPN1 confirmed she did not follow procedure for R4's glucometer, she stated no, I am supposed to wipe it down. LPN1 proceeded to obtain a germicide wipe from the top of the medication cart and quickly wiped the glucometer and returned it to the medication cart, contact time the item must remain wet was not met. Review of the Clorox healthcare bleach germicidal wipes formula container revealed the contact time was 3 minutes.2. Review of R10's Face Sheet provided by the facility revealed R10 was admitted to the facility on [DATE] with a diagnosis that included but not limited to type 2 diabetes.Review of R11's Face Sheet provided by the facility revealed R11 was admitted to the facility on [DATE] with a diagnosis that included but not limited to Type 2 diabetes.Review of R13's Face Sheet provided by the facility revealed R13 was admitted to the facility on [DATE] with a diagnosis that included but not limited to Type 2 diabetes.Review of R15's Face Sheet provided by the facility revealed R15 was admitted to the facility on [DATE] and re-admit on 04/27/25 with a diagnosis that included but not limited to Type 2 diabetes.During an observation on 10/02/25 at 4:13 PM, Registered Nurse (RN) 2 administered afternoon medications on the Rehabilitation unit to R10, R11, R13 and R15. RN2 retrieved and placed a clear plastic container identified as R10's on top of the medication cart. The container housed a glucometer and an insulin pen. RN2 opened the plastic container, removed the glucometer and placed it on to the bare medication cart. RN2 preceded to retrieve a glucometer test strip and lancet, placing both items next to the glucometer. RN2 performed hand hygiene protocol, placed gloves onto her hands, and preceded to the common area where R10 was watching television. RN2 placed the glucometer reader onto a bare table adjacent to where R10 was sitting and performed a blood sugar check. RN2 returned to the medication cart, removed one glove from her right hand, retrieved the Humalog (insulin for diabetes) pen from the plastic container, placed the pen onto the cart. RN2 retrieved a covered needle from the cart, secured it to the pen, placing back on the cart, removed the glove from her left hand, applied sanitizer to her hands and donned a clean pair of gloves. RN2 retrieved R10 from the common area and wheeled him into his room. RN2 exited R10's room, retrieved the insulin pen, returned to the room and administered his insulin. RN2 exited the resident's room, doffed her gloves, and disposed of them in the trash can located on the medication cart. RN2 failed to perform hand hygiene after doffing her gloves. During this same medication pass, RN2 retrieved R11's clear plastic container from the medication cart, sanitized her hands and donned a pair of gloves. She opened R11's plastic container which contained his insulin pen and glucometer placing on to the cart. RN2 retrieved the lancet and placed it on the glucometer gathering the resident's glucometer, test strip, and lancet she preceded to the resident's room. Once in R11's room, RN2 placed the glucometer, strip, and lancet on to the resident's bare bedside table. RN2 performed a blood sugar check, exited the room, doffed her gloves, retrieved R11's insulin pen secured the needle to the pen, placed it on the cart, RN2 sanitized