

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Alden Estates of Countryside, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1130 Collins Road Jefferson, WI 53549	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, policy review, and interviews, the facility failed to ensure that staff performed hand hygiene before and after wearing gloves during blood glucose checks for five of five resident (Resident (R) 5, R6, R7, R8, and R9) observed during blood glucose checks. This failure had the potential to place residents at risk for the spread of infection and cross-contamination. Findings include: The following was observed during observation of blood sugar administration starting on 10/03/25 at 7:07 AM with Licensed Practical Nurse (LPN)1. LPN1 was observed performing hand hygiene at her cart. LPN1 picked up a previously cleaned glucometer from the cart, before going into R5's room. LPN1 entered R5's room, donned a pair of gloves, and performed a fingerstick glucose check on R5. LPN1 exited R5's room still wearing gloves and discarded her gloves and lancet at the medication cart on 10/03/25 at 7:10 AM. LPN1 performed hand hygiene. On 10/03/25 at 7:11 AM, LPN1 donned a pair of gloves without performing hand hygiene and cleaned the glucometer. LPN1 performed hand hygiene at the cart, picked up the previously cleaned and disinfected glucometer, a lancet, and a testing strip. and proceeded to R6's room. There was an Enhanced Precautions sign on R6's room and a supply cart at the door. The sign indicated gloves and gown were to be worn during high contact resident care activities. LPN1 donned a gown and gloves from the cart and entered R6's room. LPN1 accidentally dropped the lancet on the R6's floor. LPN1 took off gown and gloves and placed them on the supply cart outside the room. LPN1 returned to her cart to retrieve a fresh lancet and returned to R6's room. On 10/03/25 at 7:16 AM, LPN1 picked up a new gown and pair of gloves from the supply cart. No hand hygiene was performed before donning gloves. LPN1 picked up the glucometer and performed the blood glucose check. LPN1 took off her gown and gloves and added them to the ones already on the supply cart. LPN1 stated she needed to get a garbage bag to dispose of the gowns. When asked why she did not place them in the trash can in the resident's room, she had no response. LPN1 wheeled R6 back to the breakfast area and then performed hand hygiene at her medication cart on 10/03/25 at 7:19 AM. On 10/03/25 at 7:20 AM, LPN1 donned a pair of gloves and cleaned the glucometer, removed the gloves, and performed no hand hygiene. LPN1 documented on her computer, touched the keyboard and mouse, reached into her pocket for cart keys, opened cart, and retrieved a lancet and testing strip. LPN1 picked up the previously cleaned glucometer and went to R7's room. On 10/03/25 at 7:21 AM, LPN1 performed hand hygiene and donned gloves. LPN1 checked R7's blood sugar and removed her gloves. LPN1 did not perform hand hygiene before applying a fresh pair of gloves to apply a topical medication on R7. After applying the topical, LPN1 removed her gloves and performed hand hygiene. On 10/03/25 at 7:26 AM, LPN1 picked up the glucometer and returned it to her medication cart. LPN1 donned a pair of gloves, cleaned the glucometer, and took off the gloves. LPN1 did not perform hand hygiene and touched the cart, the computer, and mouse. LPN1 reached into her pocket for cart keys and retrieved a lancet and testing strip. On 10/03/25 at 7:28 AM, LPN1 picked up the clean glucometer and headed to R8's room. R8's room had an enhanced precaution sign on the door. LPN1 wore a gown and gloves from the supply cart outside the room, no hand hygiene, and entered R8's room. LPN1 performed blood sugar check on R8. On 10/03/25 at 7:31 AM, LPN1 discarded the gown and gloves in the trash. LPN1 held the glucometer in one hand and placed the other hand to collect some hand sanitizer from the wall dispenser in R8's room. LPN1 cupped the sanitizer in her hand but did not use it, until she stepped out of R8's room into the hallway and reached her medication cart. LPN1 placed the glucometer on the cart and then brought her hand together to rub the sanitizer. On 10/03/25 at 7:32 AM, LPN1 donned a pair of gloves and proceeded to document on her computer with gloves on. When she finished documenting, LPN1 cleaned the glucometer. LPN1 doffed her gloves and did not perform hand hygiene. On 10/03/25 at 7:34 AM, LPN1 went to R9's room. LPN1 performed hand hygiene, performed the blood glucose check and discarded the gloves when done, without performing hand hygiene. LPN1 wheeled R9 back to the dining area. On 10/03/25 at 7:37 AM, LPN1 performed hand hygiene, wore a pair of gloves to clean the glucometer. LPN1 doffed her gloves and did not perform hand hygiene. She proceeded to document on the computer and put hands in her pocket. On 10/03/25 at 7:43 AM, LPN1 wheeled R10 back to the dining area. LPN1 donned a pair of gloves, performed no hand hygiene, and cleaned the glucometer. LPN1 doffed her gloves and did not perform hand hygiene. During an interview on 10/03/25 at 7:47 AM, the foregoing observations were discussed with LPN1. LPN1 acknowledged she had failed to perform hand hygiene before and after wearing gloves. During an interview on 10/03/25 at 1:40 PM, Infection Preventionist (IP) stated it was her expectation that staff perform hand hygiene before and after entering resident's rooms.</p>		