

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Wisconsin Dells Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Race St Wisconsin Dells, WI 53965	

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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interviews, and record review, the facility failed to have an effective pest control program in place to prevent pests and rodents from entering the building through damaged exterior doors which lead into the kitchen. This has the potential to affect the census of 52. Findings include: During an initial inspection of the kitchen, on 08/06/25 at 1:20 PM, the following concerns were observed: 1. There were two small black droppings in the dry storage room which appeared to be mouse droppings. 2. The exterior door next to the dry storage area was observed to have gaps at the bottom of the door where light from outside was observed providing access to pests and/or rodents. A secondary door in between the exterior and interior of the building, directly in front of the exterior door, was observed to have a gap at the bottom corner of the door. 3. The door to the dry storage room was not sealed across the bottom of the door, providing access to pests and/or rodents. 4. The exterior door, identified as the door utilized for food service delivery, was observed to have approximately one-inch gaps across the bottom and side of the door and a broken and splintered door frame providing access to pests and/or rodents. The above observations were confirmed by the Dietary Manager (DM) and the Corporate Dietician (CD) at the time of inspection on 08/06/25 at 1:20 PM. On 08/06/25 at 1:30 PM, the DM stated My staff member reported mouse droppings to me last week. I told the Maintenance Director (MD) The MD said they [pest control] will be out this week. Review of the pest control invoices provided by the Administrator, from 02/17/25 to 07/14/25, revealed monthly treatment for exterior bait stations, adding more bait; and treatment for ants in one specific resident room. In an interview on 08/07/25 at 09:35 AM, the MD confirmed that the DM had told him about mouse droppings the previous week and that he said the pest control would be out on Monday, however they did not arrive on Monday. Observation of the exterior doors, with the MD, on 08/07/25 at 9:50 AM confirmed the delivery door frame and door itself had large gaps around the door; the exterior door near the dry storage room had gaps; and the door directly in front of the exterior door had a gap at the bottom corner. The MD confirmed the openings could allow pests and/or rodents into the building stating that he could fix three of the four but would have to order a new food delivery door. On 08/07/25 at 10:27 AM, the Administrator, confirmed by observation and interview, that the identified doors were in need of repair to prevent pests and/or rodents from entering the building.</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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