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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525726 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Lakeview Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 962 E Garland St E West Salem, WI 54669 | |
| 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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p>40181</p> <p>Based on observation and interview, the facility did not ensure the privacy and confidentiality of resident medical records. Surveyor observed staff leave the Medication Administration Record (MAR) open with resident information visible when leaving the medication cart unattended during medication administration. This occurred for 4 residents (R) during medication administration. (R45, R48, R7 and R33)</p> <p>Findings include:</p> <p>On 05/14/24 at 7:24 AM, Surveyor observed Registered Nurse (RN) C leave the medication cart to obtain additional medication from backup supply. While RN C was away from the medication cart, Surveyor observed R45's information was visible on the MAR on top of the medication cart.</p> <p>On 05/14/24 at 11:24 AM, Surveyor observed RN F walk away from the medication cart to get ice cream from the refrigerator in the kitchenette. While RN F was in the kitchenette, Surveyor observed the MAR open with R48's information visible for anyone who walked by the cart.</p> <p>On 05/14/24 at 11:31 AM, Surveyor observed RN F prepare medications and carry them to R7 in the dining area. While RN F was away from the medication cart, Surveyor observed the MAR open on top of the medication cart with R7's information visible to anyone who walked by the cart.</p> <p>On 05/14/24 at 11:36 AM, Surveyor observed RN F prepare medications and carry them to R33 in the dining area. While RN F was away from the cart, Surveyor observed the MAR open on top of the medication cart with R33's information visible to anyone who walked by the cart.</p> <p>On 05/14/24 at 12:35 PM, Surveyor interviewed RN F about the observations of the MAR being left open with resident information visible during medication administration. RN F stated they were supposed to close the MAR every time they walked away from the cart so resident information was not visible. RN F stated sometimes they were in a hurry and forgot to close the MAR.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 05/15/24 at 6:54 AM, Surveyor interviewed Director of Nursing (DON) B about the facility policy and procedure for leaving the MAR visible on top of the medication cart when leaving the cart unattended during the medication administration. DON B stated every time the nurse leaves the cart the MAR should be put down so people walking by can not see resident's confidential information. Surveyor informed DON B of observations made during the survey of nurses leaving the MAR open with resident information visible when they left the medication cart unattended. DON B stated they should have closed the MAR when they left the cart. DON B will re-educate all staff who pass medications.</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40181</p> <p>Based on observation, interview and record review, the facility did not prepare, distribute, and serve food in accordance with professional standards for food service safety. Staff were observed not wearing hair nets or covering over facial hair while preparing and serving food in the Garden Terrace kitchenette. This had the potential to affect all 12 residents in the Garden Terrace unit.</p> <p>Findings include:</p> <p>According to the FDA Food Code 2022 documents at 2-402.11 Hair restraints: Effectiveness. (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linens and unwrapped single service and single use articles.</p> <p>Facility policy and procedure entitled Culinary Services Dress Code, last reviewed/revised 01/2024, stated in part, .Hair restraints are to be worn at all times, covering all hair .If males have beards (anything past 5 o'clock shadow) these must be covered with a beard restraint .</p> <p>On 05/14/24 at 8:16 AM, Surveyor observed Certified Nursing Assistant (CNA) E go behind the counter in Garden Terrace kitchenette while the culinary assistant was serving breakfast. CNA E was wearing a hair net, but no beard restraint to cover his facial hair. CNA E had a beard greater in length than a 5 o'clock shadow. CNA E prepared cold cereal with milk and served it to a resident in the dining room. At 8:20 AM, CNA E walked behind the counter again while the culinary assistant was serving breakfast. CNA E was not wearing a beard restraint to cover facial hair. CNA E took a coffee cup, went to the refrigerator and took some cream out, poured coffee and cream in the cup and placed the cup on a tray behind the counter. CNA E went into a back room carrying a plastic cup, came back out and placed a cup filled with ice water on a tray that the culinary assistant had placed a plate of food on. CNA E carried the tray to a resident room.</p> <p>On 05/14/24 at 11:59 AM, Surveyor observed CNA E enter the Garden Terrace kitchenette while the culinary assistant was serving lunch. CNA E was not wearing a hair net or beard restraint. CNA E picked up a plate of food prepared by the culinary assistant and carried it to a resident in the dining room. At 12:00 PM, CNA E returned to the kitchenette and applied a hair net to cover all hair on their head. CNA E did not put on a beard restraint. CNA E picked up a plate of food and delivered it to a resident in the dining room.</p> <p>On 05/14/24 at 2:05 PM, Surveyor interviewed CNA E about observations of CNA E in the kitchenette during food service for breakfast and lunch without a hair net or beard restraint on. CNA E stated they were supposed to have a hair net on every time they entered the kitchenette during food service. CNA E stated they forgot to put on a hair net a couple of times today. Surveyor asked if CNA E was supposed to be wearing a beard restraint when in the kitchenette during food service. CNA E was not sure if they were supposed to wear a beard restraint. CNA E did not remember what they were taught about covering facial hair in the food service area.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 05/15/24 at 8:27 AM, Surveyor interviewed Dietary Manager (DM) I about the facility policy for staff hair and beard coverings in the unit kitchenettes during meal service. DM I stated the expectation was all staff who go into the food service area on the units would wear hair and beard (if applicable) restraints. DM I stated they have all received education regarding that expectation. DM I stated there are hair and beard nets available in each unit kitchenette.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694</p> <p>Based on observation, record review and interview, the facility did not ensure a sanitary environment to help prevent the development and transmission of communicable diseases and infections.</p> <p>Medical equipment was not sanitized for 4 of 4 residents (R26, R22, R2, and R28) observed for reusable mechanical lifts.</p> <p>Inappropriate glove use was observed during medication pass with 2 of 4 residents (R45 and R8) observed.</p> <p>There was no sanitization of a common area table after used lancet and glucometer were placed on the table with 1 of 2 residents (R20) observed during blood glucose checks.</p> <p>Findings:</p> <p>Example 1</p> <p>Facility policy titled, MECHANICAL LIFT SANITIZING AND ROUTINE CLEANING, last reviewed 3/08/23, states in part: .All lift surfaces that make contact with staff hand/gloves or resident must be sanitized with hydrogen peroxide wipes between each resident.</p> <p>R26 was admitted on [DATE] with both short- and long-term memory problem.</p> <p>R26's diagnosis included ulcerative colitis (an inflammatory bowel disease (IBD) that causes inflammation and ulcers (sores) in your digestive tract).</p> <p>R26's Minimum Data Set (MDS) dated [DATE] indicated this resident was always incontinent of both bowel and bladder.</p> <p>On 05/14/24 at 9:50 AM, Surveyor observed Certified Nursing Assistant (CNA) D take mechanical lift (hoyer) out of R26's room and did not wipe down or wash the lift and took it to store it in another room. Surveyor asked CNA D, When do you typically wash the lifts? CNA D replied, We wash them at nighttime. Surveyor clarified, So you don't clean them in between residents, but just at nighttime? CNA D replied, Yes, that is correct, at night.</p> <p>On 05/14/24 at 9:55 AM, Surveyor interviewed Registered Nurse (RN) C. Surveyor asked, What is the process for cleaning hoyer lifts here? RN C replied, Each resident has their own hoyer sling. So, the hoyer gets cleaned once at night.</p> <p>On 05/14/24 at 11:45 AM, Surveyor interviewed Director of Nursing (DON) B about observations and interviews about cleaning lifts. DON B replied, We are already doing education with all staff about this. The staff know that they are to be cleaned when exiting the resident's room after each use.</p> <p>48793</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Example 2</p> <p>R22 was admitted on [DATE] with a Suprapubic catheter and on Enhanced Barrier Precautions (EBP).</p> <p>R2 was admitted on [DATE] with an indwelling catheter and on EBP.</p> <p>On 05/14/24 at 7:20 AM, Surveyor observed CNA G wheel the Hoyer lift outside of R22's EBP room. Surveyor did not observe CNA G wipe down the Hoyer lift.</p> <p>On 05/14/24 at 8:38 AM, Surveyor observed Certified Nursing Assistant (CNA) H enter R2's EBP room with full PPE on. CNA H performed peri care on R2. CNA H called CNA G into R2's room for assistance. CNA G entered R2's room with the Hoyer lift from the hallway. CNA G parked the Hoyer lift by the bathroom door. CNA H with gloves walked by the Hoyer lift and pushed Hoyer lift backwards with soiled gloved hands touching the handles of the Hoyer lift. CNA H doffed soiled gloves, sanitized, and donned new gloves. CNA H completed catheter care on R2. CNA H re-covered the catheter bag and hooked it to the Hoyer sling while transferring R2 to the wheelchair. CNA H and CNA G kept soiled gloves on, held onto the Hoyer lift and transferred R2 to R2's wheelchair. CNA G doffed PPE, wheeled the Hoyer lift out of R2's room and parked the Hoyer lift in the hallway.</p> <p>Surveyor did not observe CNA G wipe down the Hoyer lift with sanitizing wipes after providing care and transfer in R2's room.</p> <p>On 05/14/24 at 10:11 AM, Surveyor observed CNA H wheel the same Hoyer lift into R28's room. CNA H performed hygiene care, wiping the face with a washcloth and rolling to place the Hoyer sling under R28. CNA H hooked R28's sling to Hoyer lift, and CNA G entered R28's room to assist with the transfer. Surveyor observed CNA H and CNA G transfer R28 into the bath chair. Surveyor did not observe the Hoyer lift sanitized before using the Hoyer lift to transfer R28 from the bed to the bath chair.</p> <p>On 05/14/24 at 10:45 AM, Surveyor observed CNA H wheel R28 back to R28's room, and CNA G entered to assist in R28's room. CNA H and CNA G lifted R28 with the Hoyer lift from the bath chair to R28's bed. CNA H and CNA G rolled and dressed R28 in bed and then lifted R28 from the bed to the wheelchair.</p> <p>On 05/14/24 at 10:55 AM, Surveyor observed CNA G wheel the Hoyer lift out of R28's room and park the Hoyer lift in the hallway. Surveyor did not observe CNA G sanitize the Hoyer lift after the use of transferring R28 to the bath chair, and then back to bed after R28's bath.</p> <p>On 05/14/24 at 11:01 AM, Surveyor interviewed CNA G and asked what the process for sanitizing Hoyer lifts was between residents. CNA G indicated the expectation is to wipe down the lifts between resident use. CNA G stated, I'll admit, I did not wipe down the Hoyer lift after taking the Hoyer lift out of [R22's] room, before or after entering and exiting [R2's room], and before or after entering or exiting [R28's] room. Surveyor asked where wipes would be when CNA G does wipe the Hoyer lift between residents. CNA G indicated there were no wipe containers on the Hoyer lift, and CNA G would stock wipes on the lift going forward.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 05/14/24 at 11:16 AM, Surveyor interviewed DON B and asked what the expectation is for sanitizing lifts between residents' use, especially after using an EBP room. DON B indicated that all lifts are to be wiped down and sanitized with green top white container wipes which are located on lifts in bags. DON B indicated the facility increased the amount of lifts the facility had so that when there were EBP rooms some lifts were able to be stored in the EBP room and stay in the room for each use for that designated resident. Surveyor indicated to DON B that Surveyor did not observe CNA G sanitize the Hoyer lift used in R22, R2, and R28's rooms in between residents' cares and transfers. DON B indicated that CNA G should have sanitized lifts before each use for different residents.</p> <p>47284</p> <p>The facility policy, entitled Infection Control Precautions, dated 4/10/24, states: .Standard precautions designed to incorporate the protection against blood borne pathogens achieved by universal precautions and the protection against other pathogens achieved by body substance isolation. Standard precautions are to be used on all residents, regardless of their diagnosis or presumed infectious status, when coming into contact (or at risk of contact) with any of the following: blood, all body fluids, secretions, and excretions except sweat, non-intact skin, and mucous membranes. Standard precautions consist of .consistent and correct glove use . regular cleaning of all environmental surfaces .</p> <p>Example 3</p> <p>R45 was admitted to the facility on [DATE] and had a diagnosis that included in part seborrheic dermatitis.</p> <p>R45's provider order of Ketoconazole 2% cream topically to flaking skin on face daily am, started 11/21/23.</p> <p>On 5/14/24 at 7:12 AM, Surveyor observed Registered Nurse (RN) C during medication pass. RN C applied gloves to both hands. With gloved hands, RN C closed the computer screen, grabbed the cup of medication, cup of apple juice, and walked to R45's room. RN C knocked on R45's door and grabbed the handle to open the door. RN C gave R45 his cup of medication and cup of apple juice. Still wearing the same pair of gloves, RN C then reached into the pocket of her scrub top to get R45's ketoconazole cream. Still wearing the same gloves, RN C grabbed her glasses from the top of her head and placed them onto her face and then applied the cream to R45's face.</p> <p>The gloves worn the entire time were contaminated by touching all those surfaces and should have been changed, hand hygiene preformed, and a new pair of gloves applied before applying the cream to R45's face.</p> <p>Example 4</p> <p>R8 was admitted to the facility on [DATE] and had a diagnosis that included in part diabetes.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 5/15/24 at 7:49 AM, Surveyor observed RN C open the door of the storage room with gloves on and glucometer in hand and walked over to R8 with the same gloves still on. R8 was sitting in his broda chair in the middle of the common area. RN C held R8's hand and finger to obtain the blood sample with the lancet (device with a spring-loaded needle used to obtain blood for a finger stick). RN C then grabbed her glasses from top of her head with the gloves still on. RN C then used the lancet to obtain a blood sample from R8's finger and grabbed the glucometer to obtain the blood sample. After the blood sample was obtained, RN C took the glucometer and with the same gloves still on went back to the storage room, grabbed the door handle, and went inside the room to store the glucometer and removed her gloves. RN C did not sanitize the door handle to the storage room after grabbing it with contaminated gloves on.</p> <p>The gloves worn the entire time were contaminated by touching all those surfaces. The door handle should have been sanitized after being touched with contaminated gloves.</p> <p>Example 5</p> <p>R20 was admitted to the facility on [DATE] and had a diagnosis to include in part diabetes.</p> <p>On 5/14/24 at 7:57 AM, Surveyor observed R20 sitting on a recliner with a side table next to him in the common area. Next to the side table was a couch. RN C used the lancet to stick R20's finger and placed the used lancet, that had been in contact with blood, on top of the side table with no barrier. RN C then took the glucometer with the test strip to obtain R20's blood sample and placed the glucometer with the test strip that contained blood on top of the side table with no barrier. RN C did not sanitize the side table after removing the items.</p> <p>The side table should have been sanitized after removing the lancet and glucometer as they both had the resident's blood on them.</p> <p>Interviews:</p> <p>On 5/15/24 at 8:01 AM, Surveyor interviewed RN C and explained what observations were made during medication pass on 05/14/24 and again on 05/15/24 regarding glove use. Surveyor asked RN C what the expectation of glove use was. RN C said she should have changed her gloves or only use the gloves when needed. Surveyor asked RN C what the expectation was for placing used lancet and glucometer on top of a common area table. RN C said the table should be sanitized after use.</p> <p>On 5/15/24 at 8:50 AM, Surveyor interviewed RN J and advised what observations were observed regarding glove use. Surveyor asked RN J what the expectation was for glove use in this situation. RN J said the gloves should have been applied just prior to adding the cream and not worn throughout the entire medication pass touching all those items or get a new set of gloves after using hand sanitizer once the old pair was removed. Surveyor advised RN J what observation was observed concerning the lancet and glucometer sitting on the common area table after used on R20 with no barrier and not sanitized after completed. Surveyor asked RN J what the expectation was for placing these items on the table. RN J said a barrier should have been used and the area should have been sanitized after removing the items.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 5/15/24 at 9:31 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and Director of Nursing (DON) B to advise of the observations observed with the gloves and glucometer/lancet. DON B said she was already aware of the situation and working on education. DON B said the RN should have changed gloves or used the gloves only to apply the cream. DON B also said the common area table needed to be sanitized after the glucometer and lancet were removed.</p> |