STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015092	A. BUILDING: _____ B. WING _____	R-C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ELM GROVE	800 WALL ST ELM GROVE, WI 53122

(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 04/17/2025, Surveyors conducted a standard survey, 1 verification visit and a self-report review at Heritage Elm Grove. One deficiency was identified. The one deficiency from Statement of Deficiency (SOD) LBFM12 dated 09/27/2024 was corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 71	{N 000}		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each employee followed hand washing procedures according to Centers for Disease Control and Prevention (CDC) standards. Resident Aide P did not wash or sanitize his/her hands after each resident's medication administration. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 89 residents in the client groups of advanced age and irreversible dementia/Alzheimer's. In October 2002, the CDC published the	N 441		

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
	0015092	A. BUILDING: _____ B. WING _____	R-C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ELM GROVE	800 WALL ST ELM GROVE, WI 53122

(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 441	Continued From page 1	N 441		

"Guideline for Hand Hygiene in Healthcare Settings." This guideline sets the standard for caregivers regarding glove use and hand washing to prevent the spread of infections. The CDC has recommended that caregivers wash their hands before having direct contact with residents, after contact with a resident's intact skin, after contact with body fluids or excretions, if moving from a contaminated-body site to a clean-body site during cares, after contact with inanimate objects and after removing gloves.

On 04/17/2025 from 8:52 AM to 9:02 AM, Surveyor observed Resident Aide P administer medications to Resident 10. Resident 10 spit out his/her medications onto his/her clothes. Without wearing gloves, Resident Aide P wiped Resident 10's clothes off with a paper towel, documented on the medication cart's tablet and moved cart to next room.

Resident Aide P unlocked the cart with keys, used the computer mouse, prepped Resident 5's medications, locked cart with keys, touched Resident 5's door handle, touched oximeter, administered Resident 5's medications, unlocked cart with keys and used finger to sign out Resident 5's medications on tablet.

At 9:09 AM, Surveyor observed Resident Aide P prep and administer Resident 11's medications then sanitize his/her hands.

On 04/17/2025 at 9:19 AM, Surveyor interviewed Resident Aidee P who stated s/he thought it was okay to sanitize hands after every third resident during medication pass.

On 04/17/2025 at approximately 1:45 PM, Surveyors discussed concern of hand hygiene

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015092	A. BUILDING: _____ B. WING _____	R-C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ELM GROVE	**800 WALL ST ELM GROVE, WI 53122**

(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 441	Continued From page 2 with Regional Director A, Regional Director of Clinical Operations B, Executive Director D, and Director of Nursing Q. Director of Nursing Q stated the expectation was hands were to be sanitized between each resident during medication pass.	N 441		