

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2025
NAME OF PROVIDER OR SUPPLIER Woodside Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1040 Pilgrim Way Green Bay, WI 54304	
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 1 resident (R) (R61) of 1 sampled resident. R61 had an indwelling urinary catheter. Enhanced barrier precautions (EBP) were not implemented for R61. In addition, staff provided high-contact resident care without donning the appropriate personal protective equipment (PPE). Findings include: The facility's Enhanced Barrier Precautions policy, dated 2/3/25, indicates: This policy is implemented for the prevention of transmission of multidrug-resistant organisms (MDROs). Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high-contact resident cares. When using EBP, staff should wear a clean gown and gloves while performing high-contact resident care activities such as: transfers, personal hygiene care, wound care, showering, changing linens, assisting with toileting, and device care. Device care is defined as central line care, urinary catheter, feeding tubes, and tracheostomy cares. From 9/22/25 to 9/24/25, Surveyor reviewed R61's medical record. R61 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side and benign prostatic hyperplasia (BPH) with lower urinary obstructive and reflex uropathy. A Minimum Data Set (MDS) assessment, dated 6/24/25, indicated R61 was dependent on staff for transfers, hygiene, dressing, and mobility. The assessment had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R61 had moderate cognitive impairment. R61 was R61's own decision maker. On 9/23/25 at 11:19 AM, Surveyor observed Certified Nursing Assistant (CNA)-C empty R61's catheter leg bag. CNA-C washed hands, applied gloves, and cleansed R61's catheter port with an alcohol wipe. CNA-C emptied the contents of the bag into a urinal and again cleansed the port. CNA-C then emptied the urinal, removed gloves, and washed hands. CNA-C did not wear a gown during catheter care in accordance with the facility's EBP policy. Following the observation, Surveyor observed an EPB sign outside R61's room with CNA-C who verified CNA-C should have worn a gown during catheter care. On 9/23/25 at 12:26 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated CNA-C should have worn a gown during catheter care for R61. DON-B verified catheter care is considered high-contact resident care and confirmed the facility's EBP policy indicates staff should wear a gown during high-contact cares.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525557
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