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ELIZABETH RESIDENCE SOUTH	9355 S 48TH ST FRANKLIN, WI 53132

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N 000	Initial Comments On 12/06/2023, Surveyor completed two compliant investigations at Elizabeth Residence South. As a result, 3 deficiencies were identified. Two complaints were substantiated. Census: 31	N 000		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care,	N 247		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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positioning and body alignment, and mobility and transferring.
Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 employees obtained all task specific training.

Caregiver C and Caregiver I, who had responsibilities for providing assistance with activities of daily living, positioning, body alignment, mobility, and transferring residents did not have training in the provision of personal care prior to assuming these duties.

Findings include:

On 12/05/2023, Surveyor conducted a review of 2 employees to verify compliance with task specific training requirements. Surveyor requested training records from Acting Administrator A for Caregiver C.

Example 1

The record for Caregiver C, hired 09/28/2021, did not contain evidence of training or evidence of meeting an exemption for personal care training.

On 11/30/2023, at approximately 1:15 p.m.,

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N 247	Continued From page 2 Surveyor interviewed Licensed Practical Nurse (LPN) E. LPN E confirmed Caregiver C was responsible for providing personal cares and transferring residents. On 11/30/2023, Surveyor interviewed Caregiver C. Caregiver C confirmed s/he had provided personal cares to residents since his/her hire date. Caregiver C explained s/he came with experience. The other caregivers showed him/her how to do cares on the floor. They did not give him/her formal training on personal cares or using the electric transfer lifts. S/He just knew how to do them from past experience. Example 2 The record for Caregiver I, hired 03/30/2021, did not contain evidence of training or evidence of meeting an exemption for personal care training. On 11/30/2023, at approximately 1:15 p.m., Surveyor interviewed Licensed Practical Nurse (LPN) E. LPN E confirmed Caregiver I was responsible for providing personal cares and transferring residents. On 12/01/2023 at 4:30 p.m., Surveyor interviewed Caregiver I. Caregiver I confirmed s/he had provided personal cares to residents since his/her hire date. Caregiver I stated s/he came with experience. Caregiver I stated, "I never had any training in personal cares or how to use the lift to transfer residents." On 12/06/2021, at approximately 4:10 p.m., Surveyor interviewed Acting Administrator A regarding training. Acting Administrator A confirmed the provider did not have evidence Caregiver C and Caregiver I completed or met an	N 247		

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N 247	Continued From page 3 exemption for provision of personal care training prior to assuming these job duties. Acting Administrator A stated, "The trainings are not up to date. We are looking into purchasing an electronic training system to help us better track all trainings." Cross Reference: N0358 DHS 83.32(3)(n) Rights of Resident: Safe Environment	N 247		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) received all prescribed medications in the dosages and at intervals prescribed by the practitioner. Resident 1 did not receive correct doses of insulin from 09/08/2023 to 09/14/2023. Findings include: On 10/11/2023, the Department received a complaint alleging a resident did not receive medication as prescribed. On 11/24/2023 at approximately 9:15 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/07/2023 and discharged on 09/20/2023. The provider	N 352		

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managed and administered all Resident 1's medication. Resident 1's record identified the following:

-Resident 1's medical record contained orders for Levemir injections. The order indicated, "Inject 12 Units Subcutaneously every day at bedtime."

-Resident 1's Medication Administration Record (MAR), dated 09/08/2023 to 09/14/2023, identified no caregiver initials on 09/08/2023, 09/09/2023, 09/12/2023, 09/13/2023 and 09/14/2023 for the Levemir injections. On 09/11/2023, the MAR was signed for the Levemir injection with a note in the scheduled medication notation table reading, "No pass reason: Other problems. No needle to inject him/her with. His/Her blood sugar was 271." On 09/13/2023, the MAR was not signed for the Levemir injection. There was a note in the scheduled medication notation table reading, "No pass reason: Other problems. Not in Cart."

-Resident 1's Temporary Service Plan, dated 09/07/2023, indicated Resident 1 required diabetes management. Medication Administration read, 'Function or activity ... Diabetes Management.' Further review identified, 'Diabetic ... ongoing monitoring medication administration nutritional monitoring. Diabetic ... Blood sugar checks TID (three times a day) before meals. 3x (times) every day and as needed.' Resident 1's specific goal was identified as 'resident to maintain controlled blood glucose levels.'

-Resident 1's observation notes, dated 09/07/2023, Licensed Practical Nurse (LPN) E, wrote, "Resident arrived @ [sic] facility at 1:10 Am [sic] via Bell Ambulance. Resident is alert and oriented times 2, no c/o (complaint of) pain or

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discomfort ... Resident is general diet [sic] thin liquids, insulin dependent."

On 11/22/2023 RN G provided a copy of hospice documentation dated 11/22/2023. On 09/13/2023, Hospice Social Worker wrote in progress notes: "[Resident 1's] friend called the facility to schedule a care conference with staff and hospice team. RN [sic] [LPN E], facility director [sic], [Acting Administrator A] and [Healthcare Power of Attorney K] were present. Writer present as well as [Hospice Registered Nurse Care Manager L]. Issues were addressed such as pain management, communication about changes in patient status, and weekly med [sic] updates ... writer encouraged more thorough communication between facility staff, [hospice care] staff, and patients [sic] family to ensure there are no further issues."

On 11/22/2023 at 11:57 a.m., Surveyor interviewed RN C who explained the provider held a care conference with LPN E, Acting Administrator A, Healthcare Power of Attorney (POA) K, Friend P, Hospice Registered Nurse Care Manager (RNCM) L and Hospice Social Worker (H SW) J. RN C reported Friend P was unhappy with services; however, POA K was satisfied.

On 11/22/2023 at 12:33 p.m., Surveyor interviewed Caregiver C regarding Resident 1's unsigned MARs. Caregiver C reported s/he remembered caregivers complaining about not having what they needed for Resident 1's blood sugars. Some medications were not in the cart when they were needed, but s/he could not recall which ones.

On 11/22/2023 at 12:50 p.m., Surveyor

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N 352	Continued From page 6 interviewed Caregiver M regarding Resident 1's MARs reading 'no pass' with his/her initials. Caregiver M recalled having difficulty with Resident 1's medication being available. On 11/22/2023 at 1:15 p.m., Surveyor interviewed LPN E. LPN E reported the process for a caregiver to be delegated to administer injectable insulin medication to residents, the staff first trained with another caregiver on the floor and then LPN E would observe their skills and sign them off. The documentation would be put in the caregiver's file. Surveyor asked LPN E to describe Resident 1's care needs. LPN E recalled Resident 1 moved in at around 1:00 a.m. Resident 1 moved in quick and they were told hospice would evaluate his/her medications. LPN E explained the provider received Resident 1's pain medication right away. However, LPN E was waiting to see if hospice wanted to discontinue blood sugars and insulin and knew s/he did not have everything s/he needed. "S/He probably did not have a glucometer either." LPN E confirmed Resident 1 did not receive all prescribed medications in the dosages and at intervals prescribed by the practitioner. "We should have been giving the insulin until we knew for sure what hospice was going to do. When the residents move in, it takes a while to get the medications. It's a problem." On 11/30/2023 at 2:14 p.m., Surveyor interviewed RNCM L from hospice agency. RNCM L explained Resident 1's responsible party, POA K, never discontinued his/her diabetes medications, so the hospice agency never discontinued the diabetes medication. RNCM L confirmed Resident 1's blood sugar readings were high and reported there were inconsistencies with medications.	N 352		

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N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure 1 of 1 resident was safeguarded from environmental hazards. Resident 2's mechanical lift sling was in poor condition and tore when Resident 2 was suspended in the lift. Findings include: On 11/21/2023, the Department received a complaint alleging a resident was dropped on the back of his/her head while being transferred from bed to chair via mechanical lift. The mechanical lift sling used was reported to be in poor condition. On 12/06/2023 at approximately 12:45 p.m., Surveyor reviewed Resident 2's records and identified: - Resident 2 was admitted on 10/25/2022, with diagnosis of coronary heart disease, polyarthritis, and spinal stenosis. - Resident 2's assessment, dated 09/05/2023, indicated Resident 2 was non-ambulatory and required assistance from care staff with mobility needs. Resident 2 needed full assist using 'Hoyer	N 358		

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lift' for transferring.
- Resident 2's Individual Service Plan (ISP), dated 09/07/2023, identified Resident 2 required wheelchair and broda chair for durable medical equipment (DME). Resident 2's goal was identified as, "remain safe and free from injury with use of DME until next ISP assessment."
- Resident 2's fall report, dated 11/18/2023 at 6:00 a.m., stated, "RT (right) sling broke while s/he was being transferred."
- Resident 2's Observation Notes, dated 11/20/2023, identified LPN E documented Resident 2's incident. Observation notes read, "Writer was called by staff on 11'/18/2023 [sic] around 6:50 AM regarding incident with resident. While staff was assisting resident out of bed and into broda chair [sic] Hoyer Sling strap tore causing resident to swing and hit head on hoyer bottom base [sic] resident did receive small abrasion to top back [sic] of head."

On 12/01/2023 at 1:07 p.m., Acting Administrator A provided copy of hospice visit note dated 11/18/2023. Resident 2's on-call Hospice Nurse (RN) F note, read, "[Caregiver C] reports that caregivers had gotten patient in sling and was using Hoyer lift to get patient out of bed. Sling loop ripped causing patient to fall from the air and onto the floor. Caregivers state that patient fell 'pretty far' and hit his/her head on the ground. Staff was able to get patient into Broda chair on their own with the use of a different sling. "RN F reported assessment was conducted. Resident 2 had a skin tear to the top of his/her head measuring 6.5 x 2.5 centimeters-wound was scantily bleeding at the time of assessment with drainage and swelling around the wound to lower base of skull. On Resident 2's right side of head, RN F found reddened, swollen area, not open wound. The wound on right side of head

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measured 3 by 1.5 centimeters. RN F and Health Care Power of Attorney (POA) K assessed Resident 2's equipment. The broken sling was located on the bed and was found in poor condition with several spots fraying and loops pulling apart. Two blue loops on the sling were completely torn through and unusable. RN F contacted Hospice Administrator (HA) O, who verified via mechanical lift company, that Hospice delivered a large mesh sling to the facility on 8/28/2023. According to RN F's written report, the mechanical lift sling that tore did not appear to be the same mechanical lift sling that was delivered in August 2023 by the mechanical lift company.

On 11/30/2023 at approximately 12:00 p.m., Surveyor toured the facility with Caregiver C. Surveyor entered Resident 2's room. Caregiver C identified the full body, mechanical lift sling used on 11/18/2023 when Resident 2 fell out of mechanical lift. Caregiver C showed Surveyor the loops that hooked onto the mechanical of the sling. Surveyor observed three loops in each corner. Surveyor observed the mechanical lift sling with multiple areas frayed and loops which pulled apart. Two blue loops on the sling were completely torn through and unusable. Caregiver C stated s/he chose the loop that appeared to be the least frayed to transfer Resident 2.

On 11/30/2023 at approximately 12:05 p.m., Surveyor conducted an interview with Caregiver C. Caregiver C explained that the mechanical lift sling did not look right, but s/he did not have any additional slings to get Resident 2 out of bed. Caregiver C stated, "It never was his/her sling. I got it out of the laundry room." Caregiver C explained while transferring Resident 2 from the bed to the wheelchair, the left, upper right loop of the of the sling broke while Resident 2 was in the

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air. Resident 2 fell and scraped his/her head on the base of the mechanical lift. Caregiver C lowered Resident 2 to the ground and called LPN E, POA K, and the hospice agency. Caregiver C stated Caregiver I had reported concerns about the condition of the mechanical slings to both Acting Administrator A and LPN E. Caregiver C stated nothing came out of the conversation and nothing was ever done.

On 11/30/2023 at 1:20 p.m., Surveyor interview LPN E who recalled Caregiver C called him/her after the loop of the sling broke. LPN E recalled Resident 2 fell and scraped his/her head. LPN E explained Resident 2 "didn't have any impact."

On 12/01/2023 at 4:30 p.m., Surveyor interviewed Caregiver I who stated s/he reported there were not enough mechanical lift slings in the building to get every resident up to both Acting Administrator A and LPN E. Caregiver I recalled asking LPN E for additional training for a mechanical lift sling s/he was unfamiliar with. LPN E told Caregiver I s/he did not have time to do that with him/her. Caregiver I stated, "We clearly needed additional mechanical lift slings. There was one that was in bad shape. Ultimately, that was the mechanical lift sling that broke. I would have never used that sling."

On 12/06/2023 at 4:36 p.m., Surveyor interviewed Acting Administrator A, RN G and LPN E. Acting Administrator A confirmed that the facility did not have a mechanical lift safety policy. Acting Administrator A confirmed the mechanical lift sling used for Resident 2 on 11/18/2023 should not have been used. RN G and Acting Administrator A confirmed s/he went through all mechanical lift slings and discarded any that were worn after 11/18/2023 incident. Acting Administrator A

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N 358	Continued From page 11 educated caregivers on proper washing and drying instructions for mechanical lift slings. Acting Administrator A confirmed that the provider was not completing audits of their mechanical lift equipment or the condition of the slings before the incident occurred. Cross Reference: N0247 DHS 83.22(1)-(4) Task Specific Training	N 358		