STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016570	A. BUILDING: _____ B. WING _____	R-C 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NEW BERLIN	4461 S SUNNY SLOPE RD NEW BERLIN, WI 53151

(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 07/08/2025, Surveyor conducted a verification visit at Elizabeth Residence New Berlin. Two deficiencies were identified. Both deficiencies were repeat violations. See Statement Of Deficiency (SOD) OFRT11, dated 11/30/2022, OFRT12, dated 06/29/2023, OFRT13, dated 11/13/2023, and OCR811, dated 02/14/2025. Three of 5 deficiencies from SOD OCR811, dated 02/14/2025 were substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 28	{N 000}		
{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 observation, interview, and record review, the provider did not ensure the resident right to receive medications as ordered by the physician for 5 of 7 residents reviewed. On 04/23/2025, pharmacy delivered 1 bottle of Latanoprost 0.005% eye drops containing 50 drops for Resident 11 to be administered once in	{N 352}		

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

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{N 352}	Continued From page 1 each eye daily. On 07/08/2025, the bottle was approximately 1/8 full. On 05/19/2025, pharmacy delivered a fluticasone/salmeterol 250/50 discus inhaler containing 60 puffs for Resident 4 with 2 puffs to be administered daily. On 07/08/2025, 26 puffs remained in the inhaler. On 06/13/2025, pharmacy delivered 28 benzonatate 200 MG capsules for Resident 12 with 1 capsule to be administered daily. On 07/08/2025, 1 capsule remained in each 06/25/2025, 06/26/2025, 07/01/2025 and 07/02/2025 slots. On 03/19/2025 and 04/29/2025 pharmacy delivered 1 bottle (on each date) of Lumigan 0.01% eye drops for Resident 13. Each bottle contained 50 drops with 1 drop to be administered in each eye daily. On 07/08/2025, the 03/19/2025 bottle was nearly empty and the 04/29/2025 bottle was full. From 06/13/2025-06/24/2025, Resident 3 received incorrect doses of sliding scale insulin 3 times. This is a repeat violation. See Statement of Deficiency OFRT11, dated 11/30/2022, and OFRT12, dated 06/29/2023, and OCR811, dated 02/14/2025. Findings include: The facility is licensed as a CLASS CNA (nonambulatory) CBRF able to serve up to 30 residents within the client groups of irreversible dementia/Alzheimer's and advanced age.	{N 352}		

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{N 352}	Continued From page 2 On 07/08/2025 at 12:44 PM, Surveyor inspected medication carts and interviewed Caregiver J. On 07/08/2025, Surveyor reviewed Resident 11's, Resident 4's, Resident 12's, Resident 13's, and Resident 3's records. On 07/09/2025 at 10:02 AM, Surveyor interviewed Pharmacist K. On 07/08/2025 at 12:44 PM, Surveyor inspected the East medication cart with Caregiver J and observed: Example 1- Resident 11 One 2.5 mL bottle of Latanoprost 0.005% eye drops Pharmacy label identified: Latanoprost 0.005% ophthalmic solution Instill 1 drop in both eyes nightly Dispensed 04/23/2025 (Photo 1) Caregiver J stated Resident 11's bottle of latanoprost eye drops was approximately 1/8 full and was the only bottle of latanoprost eye drops in the medication cart for Resident 11. Pharmacist K stated a 2.5 mL bottle of Latanoprost 0.005% eye drops containing 50 drops (25 days' worth) was delivered on 04/23/2025 for Resident 11. Resident 11 was admitted 04/24/2025. Physician orders included Latanoprost 0.005% ophthalmic solution instill 1 drop in both eyes nightly (start date 04/24/2025) MAR: From 05/01/2025- 07/07/2025, staff documented administration of Latanoprost eye drops 61 times (122 drops)	{N 352}		

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{N 352}	Continued From page 3 Observation notes (summarized): 07/03/2025 7:30 PM- eye drops running low, reordered 07/08/2025 10:45 PM- eye drops are in the medication refrigerator, once opened they can be left in the medication cart. ISP dated 06/18/2025: In the area of Medication Administration- " ...Facility to be responsible for medication administration ...Resident to take medications safely from trained care staff ..." Example 2- Resident 4 1 fluticasone discus inhaler Pharmacy label identified: Fluticasone/salmeterol 250/50 discus inhaler Inhale 1 puff into the lungs twice daily Dispensed 05/18/2025 (Photo 2) Contents: 60 puffs The discus meter identified 26 puffs remaining on 07/08/2025 (Photo 3). Caregiver J stated no additional fluticasone inhaler was in medication cart for Resident 4. Pharmacist K stated a fluticasone/salmeterol 250/50 discus inhalers containing 60 puffs each was dispensed 05/19/2025 and 07/07/2025 and verified the discus meter identifies number of puffs remaining. Resident 4 was admitted 06/07/2021. Physician orders included Fluticasone/salmeterol 250/50 discus inhaler, inhale 1 puff into the lungs twice daily (start date 04/10/2025). From 05/19/2025-07/08/2025 AM, staff documented administration of Fluticasone inhaler	{N 352}		

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{N 352}	Continued From page 4 101 times. ISP dated 07/19/2024: In the area of Medication Administration- " ...Facility to be responsible for medication administration ...Resident to take medication safely from trained care staff ..." Example 3- Resident 12 1 bubble pack benzonatate 200 MG gelcaps Pharmacy label identified: Benzonatate 200 MG take 1 capsule once daily at bedtime for cough 28 capsules dispensed 06/13/2025 1 capsule remained in each 06/25/2025, 06/26/2025, 07/01/2025 and 07/02/2025 slots. (Photo 4). Resident 12 was admitted 11/26/2024. Diagnoses included chronic obstructive pulmonary disease, unspecified. Physician orders included benzonatate 200 MG take 1 capsule once daily at bedtime for cough (start date 06/15/2025). MAR: On 06/25/2025, 06/26/2025, 07/01/2025 and 07/02/2025, staff documented administration of benzonatate 200 MG. ISP dated 12/26/2025: In the area of Medication Administration- " ...Facility will be responsible for medication administration ...Resident to take medications safely from trained care staff ..." Example 4- Resident 13 Two 2.5 mL bottles of Lumigan 0.01% eye drops Pharmacy label identified (bottle 1) Lumigan 0.01% ophthalmic solution instill 1 drop	{N 352}		

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{N 352}	Continued From page 5 in both eyes once daily at bedtime for eye pressure Dispensed 03/19/2025 (Photo 5) Pharmacy label identified (bottle 2) Lumigan 0.01% ophthalmic solution instill 1 drop in both eyes once daily at bedtime for eye pressure. Dispensed 04/29/2025 (Photo 6) Caregiver J stated bottle 1 was almost empty and bottle 2 was full. Pharmacist K stated a 2.5 mL bottle of Lumigan 0.01% ophthalmic solution contains 50 drops, 2.5 mL (25 days' worth) was dispensed on each 03/19/2025 and 04/29/2025. Resident 13 was admitted 03/20/2025. Physician orders included Lumigan 0.01% ophthalmic solution instill 1 drop in both eyes once daily at bedtime. MAR: From 04/01/2025-04/28/2025 staff documented administration of Lumigan 0.01% eye drops 28 days (56 drops), from 04/29/2025- 05/30/2025 staff documented Resident 13 was out of facility, and from 05/31/2025 - 07/07/2025, staff documented administration of Lumigan 0.01% eye drops 38 days (76 drops). ISP dated 06/04/2025: In the area of Medication Administration- "...Facility to be responsible for medication administration ...Resident to take medications safely from trained care staff ..." Example 5- Resident 3 Resident 3 was admitted 12/16/2020. Diagnoses included type 2 diabetes mellitus with diabetic	{N 352}		

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{N 352}	Continued From page 6 polyneuropathy. Physician orders included insulin aspart 100U/mL flexpen inject 5 UNITS subcutaneously 3 times daily plus sliding scale, if blood sugar (BS) 131-150= 1 UNIT; 151-200 2 UNITS, 201-250 = 3 UNITS; 251-300 = 4 UNITS; 301-350 = 5 UNITS; 351-400 = 6 UNITS; 401-450 = 7 UNITS; 451-500 = 8 UNITS; if over 400 notify MD. Sliding scale start date 05/28/2025, discontinued 06/24/2025. MAR (dated 06/13/2025-06/24/2025)- BS readings and number of (incorrect) units of insulin aspart 100 U/mL administered: 06/16/2025 11:48 AM: BS 290, administered 6 units (correct 4 + 5 scheduled units = 9) 06/17/2025 10:59 AM: BS 169, administered 6 units (correct 2 + 5 scheduled units = 7) 06/19/2025 12:00 PM: BS 128, administered 8 units (correct 0 + 5 scheduled units = 5) ISP dated 01/16/2025: In the area of Medication Administration- " ...Facility to be responsible for medication administration ...Resident to take medications safely from trained care staff ..." On 07/08/2025 at 2:02 PM, Surveyor interviewed Nurse L regarding Resident 3's sliding scale insulin. Nurse L stated staff should have administered 5 units scheduled plus sliding scale amount. On 07/08/2025 at 4:28 PM, Surveyor discussed concern regarding medication administration with Administrator A, Nurse L and Assistant Administrator M. Administrator A stated staff were retrained in medication administration and they watched staff administer medications as part of the plan of correction (for N0352 DHS 83.32(3)(h)	{N 352}		

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{N 352}	Continued From page 7 Rights of Residents: Receive Medication, SOD OCR811, dated 02/14/2025). Administrator A stated they would change auditing medication carts from quarterly to weekly and the annual pharmacy review was scheduled for 08/01/2025. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration	{N 352}		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure at the time of medication administration, staff accurately documented in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. From 06/13/2025-06/24/2025, staff incorrectly documented number of units of scheduled and	{N 415}		

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{N 415}	Continued From page 8 sliding scale insulin administered to Resident 3. This is a repeat violation. See Statement of Deficiency OFRT11, dated 11/30/2022, OFRT13, dated 11/13/2023, and OCR811, dated 02/14/2025. Findings include: The facility is licensed as a CLASS CNA (nonambulaory) CBRF able to serve up to 30 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. On 07/08/2025, Surveyor reviewed Resident 3's record. S/he was admitted 12/16/2020. Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy. Physician orders included insulin aspart 100U/mL flexpen inject 5 UNITS subcutaneously 3 times daily with meals plus sliding scale, if blood sugar (BS) 131-150= 1 UNIT; 151-200 2 UNITS, 201-250 = 3 UNITS; 251-300 = 4 UNITS; 301-350 = 5 UNITS; 351-400 = 6 UNITS; 401-450 = 7 UNITS; 451-500 = 8 UNITS; if over 400 notify MD. (Sliding scale start date 05/28/2025, discontinued 06/24/2025) Medication Administration Record (MAR) dated 06/13/2025- 06/24/2025 Staff incorrectly documented only the 5 units of scheduled aspart 100 U/mL insulin and did not include the additional number of units of sliding scale insulin: 06/20/2025 12:49 PM, BS 264, administered 5 units (+ 4 units sliding scale = 9) 06/21/2025 9:39 AM, BS 156, administered 5 units (+ 2 units sliding scale = 7) 06/21/2025 11:30 AM, BS 204, administered 5	{N 415}		

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{N 415}	Continued From page 9 units (+ 3 units sliding scale = 8) 06/22/2025 9:28 AM, BS 181, administered 5 units (+ 2 units sliding scale = 7) 06/22/2025 1:13 PM, BS 259, administered 5 units (+ 4 units sliding scale = 9) 06/23/2025 11:43 AM, BS 177, administered 5 units (+2 units sliding scale = 7) Staff incorrectly documented only the number of aspart 100 U/mL sliding scale units and did not include the 5 scheduled units: 06/20/2025 4:09 PM, BS 217, administered 3 units (+5 scheduled units = 8) 06/21/2025 3:49 PM, BS 270, administered 4 units (+5 scheduled units = 9) On 07/08/2025 at 2:02 PM, Surveyor interviewed Nurse L who stated staff should have documented the total number of units of scheduled and sliding scale aspart insulin administered. On 07/08/2025 at 2:14 PM, Surveyor interviewed Caregiver N who stated s/he only documented the number of units of sliding scale insulin administered to Resident 3. On 07/08/2025 at 4:28 PM, Surveyor discussed concern regarding medication documentation with Administrator A, Nurse L and Assistant Administrator M. Administrator A stated they would follow-up with staff. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	{N 415}		