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 10/22/2025

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 10/22/2025, Surveyors conducted a verification visit at Elizabeth Residence New Berlin. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See Statement Of Deficiency (SOD) OFRT11, dated 11/30/2022. Two of 2 deficiencies from SOD OCR812, dated 07/09/2025 were substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 30	{N 000}		
N 439	83.39(1) Infection control program. The licensee shall establish and follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure all staff followed infection control standards of practice to prevent the development and transmission of communicable disease and infection for 1 of 2 residents with gastrostomy tubes (G-tubes). Syringes used to flush Resident 14's feeding tube (G-tube) were not properly cleaned, not dated with date/time opened, or replaced within 24	N 439		

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
	0016570	A. BUILDING: _____ B. WING _____	R-C 10/22/2025

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 439	Continued From page 1	N 439		

hours to prevent bacterial growth.

Findings include:

On 10/22/2025 at 9:28 AM, Surveyor accompanied Caregiver O to Resident 14's room. Lying on a towel on a table were 3 60cc syringe plungers, 2 60cc syringe barrels, 1 10cc syringe barrel, 1 10cc plunger, and several syringe brushes in various sizes. Caregiver O retrieved a 60cc syringe barrel and plunger from the table and, using the syringe and clear water, flushed Resident 14's G-tube. Caregiver O then disconnected the syringe's plunger from the barrel, rinsed them with clear water and laid them back on the towel. The freshly rinsed 60cc syringe barrel was discolored tan where the barrel narrowed to its tip (Photo1). The 2nd 60cc and 10cc syringe barrels were discolored tan where the barrels narrowed to their tips, and tan colored sediment was dried to 2 of the 60cc's plunger seals (Photo 2).

On 10/22/2025 at approximately 9:35 AM, Surveyor interviewed Caregiver O who stated Resident 14's family supplied new syringes every 2 weeks.

On 10/22/2025 at 9:36 AM, Surveyor showed Nurse L syringes on table in Resident 14's room. Nurse L stated s/he did not know why there were so many syringes, why they were not dated, and how often the syringes were replaced. Nurse L stated it appeared the tan discoloration was sediment from the formula and stated "I don't like it."

On 10/22/2025, Surveyor reviewed the facility's Feeding Tube Care policy and procedure which stated, " ...Formula containers, tubing and

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 10/22/2025

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 439	Continued From page 2 syringes shall be labeled with date/time opened and replaced per manufacturer guidelines or within 24 hours, whichever is sooner ..." On 10/22/2025 at 12:03 PM, Surveyors discussed concern of infection control with Resident 14's tube feeding syringes with Administrator A, Nurse L and Resident Manager M. Administrator A stated they would provide staff with clearer reeducation. Cross Reference: N0441 DHS 83.39(3) Handwashing	N 439		
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 follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. Caregiver O did not wash or sanitize hands between Resident 15's, Resident 3's, and Resident 16's medication passes. This is a repeat violation. See Statement Of Deficiency (SOD) OFRT11, dated 11/30/2022. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 30 residents within the client groups of physically	N 441		

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 10/22/2025

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 441	Continued From page 3	N 441		

disabled, advanced aged, irreversible dementia/Alzheimer's.

In October 2002, the Centers for Disease Control and Prevention (CDC) published the "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

On 10/22/2025 at 8:38 AM, Surveyor observed Caregiver O administer medications to Resident 15. Caregiver O then touched the computer mouse, and medication cart keys and drawer handle. Caregiver O prepped Resident 3's medications, carried the medication cup containing Resident 3's medication by its rim, and touched Resident 3's door handle. Caregiver O searched the bed blankets covering Resident 3 for his/her phone to check blood sugar with, put gloves on, and continued to search under bed blankets for phone. Caregiver O found the phone and plugged it to charge it then administered Resident 3's medication and doffed gloves. Caregiver O returned to the medication cart, documented administration of Resident 3's medications, prepped and administered Resident 16's medications, then sanitized his/her hands.

On 10/22/2025 at 9:13 AM, Surveyor interviewed Caregiver O about lack of hand washing during medication pass. Caregiver O stated s/he was new to medication administration.

On 10/22/2025, Surveyors discussed concern of lack of handwashing with Administrator A, Nurse L and Resident Manager M. Administrator A

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 10/22/2025

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 441	Continued From page 4 stated the expectation was staff were to wash or sanitize hands between each medication pass. Cross Reference: N0439 DHS 83.39(1) Infection Control Program	N 441		