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 11/13/2023

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 11/10/2023, Surveyor conducted 1 verification visit at Elizabeth Residence New Berlin. Three deficiencies were identified. Two of 3 deficiencies were uncorrected repeat violations. See Statement Of Deficiency #OFRT11, dated 11/30/2022, and #OFRT12, dated 06/29/2023. One of 3 deficiencies was a repeat violation. See statement of deficiency #DVYZ12, dated 03/23/2021. Three of 5 deficiencies from SOD #OFRT12, dated 06/29/2023 were corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 30	{N 000}		
{N 239}	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall	{N 239}		

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

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{N 239}	Continued From page 1 successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees reviewed obtained all department approved training as required. Dietary Aide G did not have training in fire safety within 90 days after starting employment. Dietary Aide G did not have training in first aid and choking within 90 days after starting employment. This is a repeat violation. See Statement of Deficiency #DVYZ12 dated 03/23/2021, #OFRT11, dated 11/30/2022, and #OFRT12 dated 06/29/2023. Findings include: On 11/10/2023, Surveyor conducted a review of 2 employees to verify compliance with department approved training requirements. Surveyor requested training records from Resident Manager A for Dietary Aide G. Fire Safety	{N 239}		

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{N 239}	Continued From page 2 The record for Dietary Aide G, hired 06/12/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 11/10/2023, at approximately 1:30 PM, Surveyor interviewed Resident Manager A. Resident Manager A confirmed the provider did not have evidence Dietary Aide G completed or met an exemption for fire safety training. On 11/10/2023, Surveyor verified Dietary Aide G was not on the Community-Based Care and Treatment training registry for fire safety. First Aid and Choking The record for Dietary Aide G, hired 06/12/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 11/10/2023, at approximately 1:30 PM, Surveyor interviewed Resident Manager A. Resident Manager A confirmed the provider did not have evidence Dietary Aide G completed or met an exemption for first aid and choking training. On 11/10/2023, Surveyor verified Dietary Aide G was not on the Community-Based Care and Treatment training registry for first aid and choking. Resident Manager A was given the opportunity to submit any additional evidence of training by 11/13/2023.	{N 239}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when	{N 389}		

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{N 389}	Continued From page 3 there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when there was a change in resident's needs, abilities or physical condition, the individual service plan was updated for 2 of 3 residents reviewed. Resident 2's individual service plan (ISP) stated s/he was transferred with both a Hoyer lift and sit to stand lift and did not specify only 2 hours daily in Broda chair. Caregiving staff used contradictory "Service Plan Task" form in lieu of ISP. Resident 9's ISP did not address interventions to prevent choking and aspiration during meals; sitting in wheelchair vs. dining room chair during meals; use of sit to stand mechanical lift for transfers; use of noodle in bed and bathroom alarm to prevent falls; and speech therapy services. Caregiving staff used incorrect and contradictory "Service Plan Task" form in lieu of ISP. This is a repeat violation. See Statement of	{N 389}		

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{N 389}	Continued From page 4 Deficiency #OFRT11, dated 11/30/2022 and #OFRT12, dated 06/29/2023. Findings include: Example 1- Resident 2 On 11/10/2023, Surveyor requested Resident 2's record including current ISP from Resident Manager A. S/he was admitted 05/06/2020. Observation notes dated 10/01/2023-11/10/2023: 10/26/2023 12:30 PM- "Hospice is changing [him/her] to a Hoyer. Also only 2 hours in the Broda chair max, [s/he] needs to lie in bed per Hospice ..." On 11/13/2023 at 4:37 PM, Surveyor received Resident 2's Service Plan Task from Resident Manager A via email. The email stated, " ...I am sending in an attachment another way staff is able to view the ISP ..." and the attachment stated " ...DME - Yes Status: ses [sic] a Broda chair , [sic] sit to stand from [name of hospice provider]. Scheduled dates: 12/20/2022 - No End Date ... Transferring - Full Assist with Hoyer lift and 2 staff ...Hoyer lift 10/26/23 ...uses sit to stand ..." ISP (not signed or dated): In the area of Transferring- " ...Full Assist [sic] with Hoyer lift and 2 staff ..." In the area of Durable Medical Equipment- " ...Broda chair, sit to stand from [name of hospice provider]. DME equipment used daily and as needed. Resident to remain safe and free from injury with use of DME until next ISP assessment ..." In the area of Skin Integrity- " ...lie down in bed after lunch Once Every Day ..."	{N 389}		

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{N 389}	Continued From page 5 Resident 2's ISP directed staff to lie him/her down in bed after lunch every day when the hospice directive was to lie in bed except for 2 hours max daily. The ISP directed staff to transfer Resident 12 with a Hoyer lift and a sit to stand lift when the hospice directive was to transfer with a Hoyer lift. Example 2 Resident 9 On 11/10/2023, Surveyor requested Resident 9's record including current ISP from Resident Manager A. S/he was admitted 10/25/2021. Speech Therapy Recertification Note (summarized)- Start of Service date 01/29/2023, Recertification date 10/31/2023. Seen for cognition and swallowing. Observation notes dated 09/01/2023-11/10/2023: 09/06/2023 8:00 PM- " ...cushion was not under [him/her] tonight when [s/he] was put to bed in [his/her] recliner chair." 09/20/2023 2:00 PM- "[S/he] had an episode of choking on meat this afternoon. Please cut pieces of food smaller for [him/her]." 11/03/2023 1:30 PM- "Resident now has a Bathroom [sic] alarm so staff is alerted when [Resident 9] goes in the BR. Keep the BR door closed at all times. Once the door is opened the alarm will sound. Hopefully this will prevent any further fall in the BR with resident trying to toilet [him/herself] ..." On 11/13/2023 at 4:37 PM, Surveyor received Resident 9's Service Plan Task from Resident Manager A via email. The email stated, " ...I am sending in an attachment another way staff is able to view the ISP ..." and the attachment stated: " ...4 wheeled walker-Instructions: [S/he] is	{N 389}		

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{N 389}	Continued From page 6	{N 389}		

able to use 4 ww [wheeled walker] with STAFF and close SBA [standby assist]. D/C [discontinue] use of 2 ww. Scheduled Dates- 03/28/2022 - No End Date ...Eating - Standby Assist Instructions: Assist resident with meal as needed; Encourage resident to help feed self. Alternate thin liquids and solids, clear mouth after eating...Chin tuck with swallowing. Cut food into 1 tsp amounts. Supervision at meals ...Status: Resident needs standby assistance during meals for monitoring of daily intake 11/21/2022-No End Date ...Physical disabilities Status: Hx Left hip fracture. Cannot [sic] walk. Scheduled dates 10/25/2021- No End Date ...sit to stand [sic] LIFT - USE ONLY WHEN [S/HE] IN [sic] IN [HIS/HER] OWN RECLINER. Status: use sit to stand only, if in recliner. 11/13/2023 - No End Date ... Safety Intervention Status: Chair alarm Scheduled Dates 10/25/2021 - No End Date ...[Name of therapy provider] Instructions: ... sees resident for speech one time a week, starting 10/31/23. PT was d/cd on 10/20/23. Status: [name of therapy provider] sees for speech as of 10 /31/23, one time a week. PT was d/cd on 10/20/23. Scheduled dates 10/31/2023 - No End Date ...Laying in bed after lunch 1-2 hours Instructions: Lay resident into bed daily after lunch, use the noodle for a bolster on the edge of the bed, to prevent [him/her] from falling out. Scheduled dates 08/10/2023 - No End Date ... Walk to/from dine [sic] with staff daily Instructions: Walk to/ from dine [sic] with staff daily with 4 ww, close SBA and w/c follow. Pt benefits from sitting in **w/c vs dining room chair . ** 04/04/2022 - No End Date ... Walking-Non-Ambulatory (staff propels) Status: Resident is currently non-ambulatory. Resident is w/c bound at this time and requires assistance from care staff with mobility needs. Hx Left hip fracture. [S/he] may propel w/c with [his/her] feet. 01/04/2023 - No End Date ..."

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{N 389}	Continued From page 7 ISP (not signed or dated): In the area of Eating-" ...needs standby assistance during meals for monitoring of daily intake ..." In the area of Transferring- " ...Assist of one to stand and pivot only ..." In the area of Walking- "Resident is currently non-ambulatory. Resident is w/c [wheelchair] bound at this time ...[s/he] may propel w/c with [his/her] feet ...May need to be pushed in wheelchair by care staff, as resident unable to propel self ..." In the area of Emergency Evacuation- " ...will require extensive assistance with evacuation procedure. Resident may need assistance with mobility or pushed in w/c. Resident will need assistance with getting out of bed from care staff ..." In the area of Propensity to Choke on Certain Foods- " ...at risk for coking related to swallowing deficit ...diet changed to mechanical soft ...Resident to remain safe. Resident to consume appropriate diet according to MD order ..." In the area of Safety Interventions- " ...4 wheeled walker As Needed Every Day ...chair alarm ...Monitor ongoing residents [sic] need s for safety interventions ..." The ISP did not address: sleeping in recliner; alternating thin liquids and solids, clearing mouth after eating, chin tuck when swallowing, cutting foods into 1 tsp amounts; use of sit to stand for transfers including during emergency evacuations; use of noodles at edge of bed and bathroom alarm to prevent falls; and Speech therapy. On 11/10/2023 at 12:52 PM, Surveyor interviewed Med Tech F who stated Resident 2 was	{N 389}		

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{N 389}	Continued From page 8 transferred with a Hoyer lift. Med Tech F stated Resident 9 was transferred with 2 assist and not with a sit to stand mechanical lift transfer. On 11/10/2023 at 12:57 PM, Surveyor interviewed Resident Manager A who stated Resident 9 was a 2 assist pivot transfer and was seen by physical therapy. Resident Manager A stated staff followed the facility ISP for hospice residents, not the hospice care plan. On 11/13/2023 at 3:59 PM, Surveyor discussed concern of ISPs not updated when resident's needs changed with Resident Manager A and RN B. RN B stated ISP updates may not show up on the printed ISP's but staff were able to see the updated ISP in the computer. RN B stated s/he just updated Resident 9's ISP to include speech therapy because it had changed during the last week or two. Resident Manager A stated staff use the "Service Plan Task" forms which are abbreviated versions of the ISPs.	{N 389}		
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.	N 415		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure staff documented in the resident record the dosage of all medications administered.

From 10/01/2023-11/10/2023 AM, staff did not document number of units of sliding scale insulin administered to Resident 6 for 121 of 121 administrations.

From 10/01/2023-11/10/2023 AM staff did not document number of units of sliding scale insulin administered to Resident 11 for 109 of 121 administrations. The number of units of sliding scale insulin listed on Resident 11's medication administration record (MAR) did not match number of units of sliding scale insulin ordered by physician increasing risk of medication error.

This is a repeat violation. See Statement of Deficiency #OFRT11, dated 11/30/2022.

Findings include:

Example 1- Resident 6
Resident 6 was admitted 12/16/202. Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy. Physician orders included Insulin ASPA Inje Flexpen/Novalog Injext per sliding scale three times daily: 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 450 notify MD (start date 09/07/2023).

Medication Administration Record- From 10/01/2023 to 11/10/2023 number of units of

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sliding scale insulin administered were not documented on the MAR.

Observation Notes- From 10/01/2023 to 11/10/2023 number of units of sliding scale insulin administered were not documented in observation notes.

From 10/01/2023-11/10/2023 AM, Resident 6's record did not include number of units of sliding scale insulin administered.

Example 2- Resident 11

On 11/10/2023 at 11:33 AM, Surveyor observed Med Tech F take Resident 11's blood sugar, the reading was 290. Med Tech F checked a handwritten note taped to the inside of a pencil box containing Resident 11's diabetic supplies (Photo 1). The note stated "[Resident 11] 9/8/23 Humalog/Lispro Insulin call [name of physician services] if BS >400 or less than 60 ...Inject per sliding scale 3x a day before meals:
71-14 9 = 0
150-200 = 2 units
201-250 = 6 units
251-300 = 8 units
301-350 = 10 units
351-400 =12 units ..."

Med Tech F did not verify number of units of sliding scale insulin with the MD order.

On 11/10/2023 at 11:39 AM, Surveyor observed Med Tech F administer the correct dose of 8 units of Humalog/Lispro sliding scale insulin to Resident 11.

On 11/10/2023, Surveyor reviewed Resident 11's record. Diagnoses included type 2 diabetes

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mellitus with stage 4 chronic kidney disease, with long-term current use of insulin.

Physician orders included Humalog KwikPen (U=100) Insulin 100 unit/ml subcutaneous; INJECT PER SLIDING SCALE THREE TIMES A DAY BEFORE MEALS, 71-149=0, 150-200=2, 201-250=6, 251-300=8, 301-350=10, 351-400=12, >400 call MD.[sic]; Call Md [sic] if <60 (start date 09/08/2023).

October and November 2023 MARs-
Insulin Lispro Kwikpen 100U/ML (Humalog)-
Inject subcutaneously three times daily per SS:
71-149= 0
150-200= 2 Units
201-250= 6 Units
351-300 = 8 Units (should be 251-300)
301-350= 10 Units
351-400= 12 Units

On the MAR's "Scheduled Medication Notations," staff documented sliding scale insulin was held 10/10/2023 at 7:34 AM, 10/14/2023 at 9:21 AM, 10/20/2023 at 8:34 AM, 10/23/2023 at 7:42 AM, 10/24/2023 at 7:58 AM, 11/02/2023 at 4:12 PM, 11/03/2023 at 8:28 AM, 11/06/2023 at 7:59 AM, and 11/09/2023 at 3:53 PM.

Observation notes dated 10/01/2023-11/20/2023: On 10/09/2023 at 10:00 AM, staff documented blood sugar of 433 and MD notification of >400 blood sugar. On 10/25/2023 at 3:15 PM, staff documented blood sugars: AM=349; >600 after lunch and notification to MD; 1 hour later=321; 3:45 PM=56; and 4:15 PM=138. On 10/31/2023 at 6:15 PM staff documented blood sugar 137.

From 10/01/2023- 11/10/2023 AM, Resident 11's record did not contain any additional blood sugar

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N 415	Continued From page 12 readings. On 11/10/2023 at 1:37 PM, Surveyor interviewed Resident Manager A who stated they switched pharmacies on 08/08/2023 and s/he was unable to find number of units of sliding scale insulin administered to Resident 6 or Resident 11 in the electronic MAR for either resident since switching pharmacies. On 11/10/2023 at 2:20 PM, Surveyor interviewed Med Tech F who stated the number of units of sliding scale insulin were not documented for Resident 6 or Resident 11 because the electronic MAR no longer prompted staff to enter the number of units. On 11/10/2023 at 3:15 PM, Surveyor discussed concern of Resident 11's medication list and MAR not matching the physician order for sliding scale insulin and no documentation of number of units of sliding scale insulin with Resident Manager A. Resident Manager A stated s/he was not sure how long the order on the MAR and med sheet were incorrect and staff followed the handwritten sliding scale insulin order in the diabetic supply boxes. Resident Manager A stated inconsistencies between the documents could potentially cause a medication error. Resident Manager A stated after earlier discussion with Surveyor on 11/10/2023 s/he called pharmacy requesting they fix the MARs to prompt staff to document number of units of sliding scale insulin administered.	N 415		