STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525639	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Elizabeth Nursing Home	109 S Atwood Avenue Janesville, WI 53545

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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46659 Based on interview, record review, and facility policy review, the facility failed to notify the physician when 1 of 3 sampled residents reviewed discharge (R1), left the facility against medical advice (AMA). Findings included: A facility policy titled, Individual Discharge, with a review date of 08/10/2023, revealed, B. Discharges Against Medical Advice 1. Staff to complete Discharge Against Medical Advice (AMA) assessment. Per the policy, 3. Staff to notify Physician, Adult Protective Services (APS), Activated Power of Attorney for Health Care agent, or Guardian, as indicated. R1 was admitted to the facilty on 05/07/24. A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/12/24, revealed R1 discharged from the facility on 05/12/2024. R1's Progress Note, dated 05/12/24 at 1:30 PM, revealed Resident #1 left the facility AMA with a family member. R1's Progress Notes for the timeframe 05/07/24 to 05/12/24, revealed no evidence to indicate the physician was notified. During an interview on 06/21/24 at 11:24 AM, the Executive Director stated the physician was not notified R1 left the facility AMA. During an interview on 06/21/2024 at 3:00 PM, LPN E (Licensed Practical Nurse) stated the physician must be notified if a resident left the facility AMA.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46659 Based on interview, record review, document review, and facility policy review, the facility failed to timely report an allegation of misappropriation for 1 of 7 (R1) sampled residents reviewed for abuse. Findings include: A facility policy titled, Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program with a review date of 11/08/2023, indicated, It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility and to other officials in accordance with State law through established procedures. R1 was admitted on [DATE] with a medical history that included diagnoses of fracture of the right femur, chronic pain, and opioid use. The facility incident report, completed by the Executive Director (ED) and dated 05/12/24, revealed on 05/10/24, R1 reported to a licensed practical nurse that their family member always took their money and used it to buy drugs. The incident report revealed the ED was notified of the allegation on 05/12/24, who then notified the local police department and adult protective services on 05/13/24. The Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report revealed the facility notified the state agency of R1's allegations of misappropriation of resident property on 05/21/24. During an interview on 06/19/24 at 2:18 PM, the ED stated she found out about the allegation of misappropriation of resident's property on 05/11/24 and reported it to the state agency on 05/13/24. The ED stated that she thought she submitted all of the documentation, but probably did not submit it timely. During a follow-up interview on 06/19/2024 at 3:10 PM, the ED stated she knew she was outside of the reporting period, but went ahead and reported the incident.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 46659 Based on interview, record review, and facility policy review, the facility failed to arrange home health services for 1 of 5 sampled residents reviewed for discharge (R55). Findings included: A facility policy titled, Individual Transfer and Discharge, reviewed on 02/21/24, revealed, I. Policy: The Interdisciplinary Team will facilitate successful individual transfer and/or discharge while, while complying with applicable regulation. The policy specified, F. Records 1. Upon transfer or discharge of an individual, the appropriate documents shall be prepared and provided to the facility admitting the individual. An Admission Record revealed the facility admitted R55 on 12/21/23. According to the Admission Record, the resident had a medical history that included diagnoses of orthopedic aftercare following surgical amputation, acute right ankle and foot osteomyelitis, acquired absence of other right and left toes, and peripheral vascular disease. The Admission Record revealed R55 discharged home with home health services on 01/30/2024. R55's care plan, initiated on 12/21/23, indicated the resident wished to return home after therapy was complete. Interventions directed staff to make arrangements with required community resources to support R55's independence post-discharge. A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/30/24, revealed R55 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated R55 was discharged home under the care of an organized home health service organization on 01/30/24. R55's Progress Notes, dated 01/30/24, revealed the resident was going to discharge home on 01/30/24 with in-home home health services through home health to include a registered nurse, physical therapy, and occupational therapy to evaluate and treat based on the assessment. R55's Progress Notes, dated 02/02/24 at 3:03 PM, revealed a facility staff member received a telephone call from R55, who stated they had not yet been contacted or seen by home health. During an interview on 06/20/24 at 2:53 PM, the Assistant Director of Nursing (ADON) stated R55 discharged from the facility on 01/30/24 and when the resident called her on 02/02/24, she realized the resident's home health services had not been ordered. The ADON stated it was at the point that she submitted the referrals for in-home health services for the resident. The ADON stated she did inform the resident to go to the emergency department for any wound care that they needed until home health was able to see them. The ADON acknowledged the resident's home health referrals were not made until the resident called her on 02/02/2024. During an interview on 06/20/24 at 4:10 PM, the Executive Director (ED) stated the nursing team was responsible to make sure the discharge referrals were sent to the home health agency. The ED stated she was not sure if R55's referral for home health services was set up. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/21/2024 at 8:15 AM, the Director of Nursing stated he expected the nursing staff to ensure the residents had everything set up for their referral before they were discharged .