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	07/17/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not ensure that self-administration of medications was determined to be clinically appropriate for 2 (R5 and R4) of 3 residents reviewed out of a sample of 6 residents. Surveyor observed R5 to have medication at bedside. R5 does not have a self-administration of medication assessment completed and staff indicated medications should not be left at beside for R5. Evidenced by: The facility policy titled, Self-Administration of Medications, dated 1/18, states, in part; .In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer .A. if the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process . Example 1 R5 was admitted to the facility on [DATE] with a diagnoses including heart and kidney disease, aftercare following joint replacement surgery, depression, anxiety disorder, osteoporosis, difficulty in walking, muscle weakness, unsteadiness on feet, and reflux disease. On 7/17/24 at 9:45AM, Surveyor noticed a half of a pill at bedside and no nurse present. Surveyor asked R5 if she has medication left at beside. R5 indicated she did not have an assessment completed but staff leave medication at beside because she (R5) is dependable. R5 indicated the medication is a vitamin and she will take it once she wakes up. Surveyor reviewed R5's care plan, orders, and MAR/TAR (Medication Administration Record/ Treatment Administration Record). R5's documentation does not have any documentation indicating R5 can safely administer medications on own. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 2:45PM, DON B (Director of Nursing) indicated R5 does not have a self-administration of medication assessment. DON B indicated R5 is not able to safely administer medications on own. DON B indicated medications should not be left at R5's bedside. The facility failed to assess residents to ensure resident can safely self-administer medications. 50228 Example 2 On 7/17/24 at 9:41 AM, Surveyor interviewed R4. Surveyor asked R4 if medications are given to her or if they are left at her bedside. R4 stated staff generally bring her medications into her room and leave them on her bedside table. R4 stated, I am usually somewhere between sleep and awake when they come in. I don't like when they hover over me, so they leave the medications on the bedside table, and I take them within the hour. Surveyor asked R4 if the facility had performed an assessment for safe medication administration. R4 stated she did not recall an assessment. Surveyor reviewed R4's care plan, orders, and MAR/TAR (Medication Administration Record/Treatment Administration Record). R4's documentation does not have any notation indicating that R4 can safely self-administer medications. On 7/17/24 at 2:28 PM, Surveyor interviewed DON B (Director of Nursing). DON B stated that R4 does not have a self-administration of medication assessment. DON B stated that medications should not be left at R4's bedside.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment all alleged violations were thoroughly investigated, and that steps were taken to prevent further potential abuse for 2 of 3 residents (R4 and R6) reviewed for abuse. On 6/23/24, the facility became aware of an alleged violation of abuse between R4 and R6 and did not conduct an investigation. Evidenced by: The Facility policy entitled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 11/8/2023, states in part; Procedure: *Individuals will be protected from abuse, neglect, and harm while they are residing at the facility *No abuse or harm of any type will be tolerated. *Individuals and staff will be monitored for Protection .The facility will follow the attached Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program to comply with the seven-step approach to abuse and neglect detection and prevention. R4 was admitted to the facility on [DATE] with diagnoses that include, in part: Sjogren syndrome (disorder of immune system causing dry eyes and mouth), morbid obesity, depression, and anxiety disorder. R4's Minimum Data Set (MDS) with target date of 6/21/24 states R4 has a BIMS (Brief Interview of Mental Status) of 13, indicating R4 is cognitively intact. R4's 6/23/24 Progress Behavior Note states, pt (patient) has exhibited repeat behaviors during mealtimes towards other residents. Pt is easily irritated by other residents in the dining room. During this specific meal (6/23/24 dinner) care staff had brought another resident to the dining room at a different table from where the pt was already sitting, this other resident began to aspirate (inhale food/fluid into lungs) and cough due to an ongoing medical condition. Pt yelled at the other resident telling them to knock it off and shut up, the care staff who has seen the pt do this many times asked the pt to stop and explained that the resident cannot help the aspirations and that it hurt this residents' feelings the way they had talked to them . R4's 7/10/24 Psych (Psychiatric/Mental Health) Follow up note states, . 6/23-26 easily irritated; yelling at other residents in dining area, using foul language with staff . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 9:41AM, Surveyor interviewed R4 and asked if she had any concerns. R4 stated, sometimes the staff snaps at me. Surveyor asked for clarification. R4 stated, there is a resident who comes to the dining room and he gags. They hadn't told me that this was a medical condition. I told him he needed to stop. Staff then told me that he couldn't help it and that I shouldn't make comments to him. I didn't know he had a medical condition. On 7/17/24 at 12:17PM Surveyor interviewed CNA F (Certified Nursing Assistant) and asked if she recalled an incident that she documented on 6/23/24 between R4 and R6. CNA F stated she recalled R4 yelling at R6 in the dining room, telling him to knock it off and shut up. CNA F stated this had happened before and she felt she needed to speak up. CNA F stated that she asked R4 to stop making comments to R6, as R6 could not help his situation. CNA F stated that she moved R6 to a different table to offer separation. Surveyor asked if CNA F had updated anyone about the situation. CNA F stated, I don't recall who I told; then stated, I told LPN E (Licensed Practical Nurse). On 7/17/24 at 12:37PM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked if she recalled being updated about an incident on 6/23/24 between R4 and R6. LPN E stated, yes R4 was being mean to R6. She often makes comments after her husband makes comments. Surveyor asked LPN E if any intervention was made regarding the incident. LPN E stated that CNA F moved R6 to another table, separating the residents. Surveyor asked LPN E if this incident could be considered a resident to resident altercation or abuse. LPN E said, yes it could be. Surveyor asked LPN E what should occur if there is an incident of resident to resident altercation or abuse. LPN E stated the residents would need to be separated and an incident report would need to be completed. Surveyor asked LPN E if further action was taken following the incident. LPN E stated that she reported the situation to the floor nurse who was agency. LPN E stated she was unaware if any further action was taken by the agency nurse. LPN E stated, depending on what a resident says to another resident, it could be considered abuse. LPN E stated, I need to ask DON B (Director of Nursing) for clarity about what needs to be reported. On 7/17/24 at 2:55PM, Surveyor interviewed DON B and asked if a resident yells at another resident, stop that shut up, what should happen next? DON B stated, I expect staff to redirect the residents. If it is a one time thing, it is not such an issue. It is a reoccurring thing, then there should be further intervention. DON B stated, CNA F was upset as R4 had been yelling at a resident and at CNA F, but I thought the situation resolved itself. Surveyor asked DON B if a resident is yelling repeatedly would further intervention be warranted? DON B stated, yes, I would expect a grievance or something more for that. Surveyor asked DON B if the 6/23/24 dining incident had been investigated when reported? DON B stated, I spoke to CNA F and it seemed that the situation was resolved by removing R6 from the table. I didn't ask if this was a one time incident or a repeated incident. Surveyor asked if a resident yelling to another resident to 'shut up' should be investigated? DON B stated, they weren't trying to get at each other. Had I known that this was more than a one time thing, I would've had SW I (Social Worker) talk with R4. DON B stated, myself, SW I, or NHA A (Nursing Home Administrator) could have done more investigation to find the root cause. Yelling at another resident does deserve further follow up. Surveyor asked if DON B was aware of the 7/10/24 Psych Follow up note. DON B stated that after Psychiatric follow up visits and notation, there is a team meeting with focus on any medication changes. Surveyor asked DON B if there is a procedure for reviewing the Psych Follow Up notes when written. DON B stated, knowing now about the Progress Behavior Note from 6/23/24 and the Psych Follow Up note from 7/10/24, I'd have elevated this situation and done an investigation. The facility was aware of a potential verbal abuse allegation between R4 and R6 and an investigation was not completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility failed to provide social service assistance for 4 (R2, R5, R3, and R4) of 4 residents reviewed for social services. R2, R5, R3, and R4 were not assisted with their care conference meetings. The facility indicated they went several months without a social worker. The facility failed to support all residents in having care conference meetings at least quarterly to ensure person centered care and goals were priority while residing at facility. Evidenced by: The facility policy titled, Individual Advance Care Planning, dated 2/21/24, states, in part; .Individual, guardian and/or their individual representative will be provided the opportunity to discuss advance care planning with appropriate interdisciplinary team members and providers .B. Upon admission/re-admission, change in condition, and at Care Conferences: 1. Advance Care Planning will be discussed and/or verified 2. The resources available in the skilled nursing facility to treat symptoms and conditions will be discussed as appropriate . Example 1 R2 was admitted to the facility on [DATE] with a diagnoses including alcohol polyneuropathy, hypertension, insomnia, restless leg syndrome, depression, hypercholesterolemia, and reflux disease. R2 did not have a care conference meeting at all for 2024. Example 2 R5 was admitted to the facility on [DATE] with a diagnoses including heart and kidney disease, aftercare following joint replacement surgery, depression, anxiety disorder, osteoporosis, difficulty in walking, muscle weakness, unsteadiness on feet, and reflux disease. R5 has been at facility since 5/17/24. R5 did not have a care conference meeting at all since admission. On 7/17/24 at 2:45PM, DON B (Director of Nursing) indicated the facility went several months without a social worker. DON B indicated they now have a social worker. DON B indicated that everyone was assisting with social worker duties and trying to keep up on tasks. DON B indicated R5 did not have a care conference meeting at all since admission. DON B indicated R2 did not have a care conference meeting at all for 2024. Of note, R2 discharged from facility on 6/15/24. DON B indicated social worker has now set up R5's care conference meeting. It is important to note R5's care conference meeting was scheduled after Surveyor brought it to the attention of DON B. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 4:40PM, ADON C (Assistant Director of Nursing) indicated if R2 and R5 had a care conference meeting it would be documented in progress notes. ADON C indicated the facility went several months without a social worker and everyone was assisting with tasks. At 6:50PM, ADON C indicated care conference meetings were not occurring consistently at the facility while they were without a social worker. The facility failed to support all residents in having care conference meetings to ensure person centered care and goals were top priority while they resided at facility. 50228 Example 3 R3 was admitted to the facility on [DATE] with diagnoses that include, in part: chronic diastolic heart failure, hypertensive heart disease with heart failure, depression, atherosclerotic heart disease of native coronary artery, and angina pectoris. R3 did not have quarterly care conference. R3's last care conference was 2/12/24. Example 4 R4 was admitted to the facility on 9/7/2023 with diagnoses the include, in part: Sjogren syndrome, morbid obesity due to excess calories, essential hypertension, depression, and anxiety disorder. R4 did not have quarterly care caonference. R4's last care conference was 1/2/24.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility did not develop and implement a discharge planning process that included preparation for discharge, ensuring discharge needs are identified and incorporated into a discharge planning care plan for 1 (R2) of 3 reviewed out of a total sample of 5 residents. Facility staff knew R2 had a plan to discharge home however, the facility was not discussing R2's discharge plan with R2. On 6/15/24 R2 decided to discharge home without a safe discharge plan in place. The facility was aware of R2's desire to return home but was not working on a safe discharge plan. Evidenced by The facility policy titled, Individual Transfer and Discharge, dated 2/21/24, states, in part; .The interdisciplinary Team will facilitate successful individual transfer and/or discharge, while complying with applicable regulations . R2 was admitted to the facility on [DATE] with a diagnoses including alcohol polyneuropathy, hypertension, insomnia, restless leg syndrome, depression, hypercholesterolemia, and reflux disease. R2's care plan states, in part; .Focus: The resident wishes to remain in the facility for a long stay. 5/17/21 revision on 5/20/22. Goal: The resident will be able to verbalize/communicate required assistance if discharge plans change. 5/17/24 revision on 2/13/24. Interventions: A new care conference will be set up if resident's discharge plans change 5/20/22. At home, resident has a walking, cane, and exercise bike 5/17/21. Encourage the resident to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress 5/17/21. Establish a pre-discharge plan with the resident/family/caregivers and evaluate progress and revise plan 5/17/21 revision 6/10/21. Evaluate and discuss with the resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits, and needs for maximum independence 5/17/21. SIL states his home may be condemned 5/17/21. Make arrangements with required community resources to support independence post-discharge 5/17/21 revision 6/10/21. Referral to be made to the ADRC (Aging and Disability Resource Center) 5/17/21. Resident declined a meeting with AA (Alcoholics Anonymous) and counselor 5/17/21. Residents house needs to be cleaned (according to the city) in order for him to return 5/27/21. It is important to note there has been no new interventions since 2022 documented in R2's care plan to ensure a safe and successful discharge. It is also unclear in R2's discharge care plan what R2's goal was for discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 12:15PM, LPN E (Licensed Practical Nurse) indicated she was the nurse that was working the evening of 6/15/24. LPN E indicated staff came and got her because R2 was packing his bags and told staff he wanted to say goodbye to LPN E. LPN E indicated R2 was leaving to go home. LPN E indicated she educated R2 on the importance of a safe discharge. LPN E indicated R2 said he would wait while she called the on-call doctor. LPN E indicated the on-call doctor would not approve R2's discharge because they did not know R2. LPN E attempted to educate R2 on the importance of having his medications. R2 told LPN E he would be fine and didn't need his medications. LPN E indicated R2 had a house in town and that R2 had hired people to fix it up. On 7/17/24 at 1:00PM, CNA J (Certified Nursing Assistant) indicated she worked with R2 and knew him well. CNA J indicated R2 went back home. CNA J indicated R2 has a house in town, and he had hired workers to fix it up. CNA J indicated R2 wanted to go back home. CNA J stated R2 often spoke of going home soon and staff knew this was his plan. On 7/17/24 at 1:10PM, CNA K indicated R2 really wanted to go home. R2 hadn't been able to go home because he had some issues that needed to get fixed before he could go back. CNA K indicated R2 hired people to fix his house and that R2 showed CNA K the pictures of the updates to the house. CNA K stated R2 spoke often of returning home and staff knew his plan was to return home soon. On 7/17/24 at 2:45PM, DON B (Director of Nursing) indicated the facility had gone several months without a social worker and everyone was jumping in to get tasks done. DON B indicated R2 would talk about going home and that DON B thought R2 had left AMA (against medical advice). At 3:20PM, DON B indicated R2 had a desire to go home eventually. On 7/17/24 at 7:00PM, DON B indicated R2's goal regarding discharging had changed often while he was at the facility. DON B indicated R2's discharge care plan should have been current, reflect current desires and appropriate interventions. DON B indicated this would have been important for a safe discharge. Surveyor shared with DON B that staff were aware of R2's desires to go home and if a robust discussion would have taken place appropriate community supports, notifications, orders, and medications could have been in place to ensure a safe and successful discharge. DON B indicated understanding. The facility failed to support R2 in developing a safe and successful discharge goal and care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50228 Based on observation, interview, and record review, the facility did not ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good personal hygiene. R4 did not receive a shower between 7/5/24 and 7/17/24. Evidenced by: Surveyors requested a policy related to ADL (Activities of Daily Living)/Showers and no further information was provided by the facility. R4 was admitted to facility on 9/7/23, with diagnoses that include, in part: need for assistance with personal care, morbid obesity due to excess calories, anemia (not enough oxygen in the blood which can cause tiredness, weakness, and shortness of breath), depression, urinary incontinence (inability to control bladder function), muscle weakness, and difficulty in walking. R4's Minimum Data Set (MDS), with target date of 6/21/24, indicates R4 has a BIMS (Brief Interview of Mental Status) of 13, indicating resident is cognitively intact. R4's Care Plan indicates: Focus- R4 has an ADL self-care performance deficit r/t (related to) weakness, morbid obesity, anemia, and depression. Goal-the resident will improve current level of function in personal cares to assisting with upper body; lower body as able (revised 4/3/24). Interventions-Set up for personal cares and 1A (assist of one) with those she is unable to perform. Note: Bathing/Showering section of care plan does not indicate amount of assistance required. On 7/17/24 at 9:41AM, Surveyor interviewed R4 and asked if she gets her showers as scheduled. R4 stated, I haven't had a shower in 2 weeks, look at my greasy hair. Surveyor observed R4's hair appeared greasy. Surveyor asked R4 if she had told staff about her missed shower. R4 stated, yes, I have asked, it goes in one ear and out the other. On 7/17/24 at 3:42PM, Surveyor interviewed CNA G (Certified Nursing Assistant) and asked if she is able to complete showers as scheduled. CNA G stated it depends on the day. Sometimes there are only 2 CNAs, and we are unable to complete all the showers. Surveyor asked CNA G what is done when a shower is missed. CNA G stated, I ask the resident if we can try to complete the shower the next day. CNA G indicated that the facility cannot find R4's shower sheets, normally her showers are on the Friday evening shift. Surveyor asked CNA G where showers are documented. CNA G stated that the CNA documents on a shower sheet, then gives the sheet to the nurse on duty to sign, then forwards the sheet to ADON C (Assistant Director of Nursing). Surveyor asked CNA G if R4 ever refuses a shower. CNA G stated that she has refused for a male CNA but has not refused recently. On 7/17/24 at 4:20PM, Surveyor interviewed DON B (Director of Nursing) and asked if there were shower sheets for R4 from 7/5/24 to present. DON B stated, not that I have found. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 4:34PM, Surveyor interviewed ADON C and asked what the expectation is if a shower is not completed as scheduled. ADON C stated it should be passed along to the next shift to be completed, it should be reported to the nurse, and it should be documented on the 24-hour board. ADON C stated there is no information regarding R4's shower on the 24-hour report sheet for the requested dates of 7/5/24 to present. R4 informed Surveyor that she had not received a shower in two weeks and the facility failed to provide evidence a shower was provided from 7/5/24 through 7/17/24.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39849 Based on record review and interview, the facility did not ensure a Registered Nurse (RN) worked for 8 consecutive hours in a day, 7 days a week. This has the potential to affect all 32 residents (R) residing within the facility. On Saturday July 6, 2024, and Sunday July 7, 2024, the facility did not have an RN in the building 8 consecutive hours. On 6/17/24 at approximately 4:00 PM, after reviewing the facility provided schedules, surveyor interviewed ADON C (Assistant Director of Nursing) regarding RN (Registered Nurse) coverage. Surveyor requested ADON C review the schedules and indicate which nursing staff listed were RNs. Nursing staff listed for Saturday July 6, 2024 and Sunday July 7, 2024 schedules were not noted to be RNs. ADON C indicated there is not always a Registered Nurse in the facility on weekends for 8 consecutive hours.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on interview, and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 residents (R1). R1 was admitted to the facility with a diagnoses of C. diff (Clostridium difficile) infection and isolation precautions were not implemented per current standards of practice. This is Evidenced by: The facility policy, Outbreak and Isolation Procedures, with a review date of 9/20/23, indicates, in part: .3. Isolation precautions are encouraged for individuals and/or staff for any contagious element according to the CDC (Centers for Disease Control) guidelines . According to the CDC website (https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html) C. Diff: Facts for Clinicians, Treatment and Recovery: .Isolate patients with possible C. diff immediately, even if you only suspect CDI (C. diff Infection) .If CDI is confirmed: Continue isolation and contact precautions. R1 was admitted to the facility on [DATE] with diagnoses that include, in part: enterocolitis due to clostridium difficile (inflammation that occurs throughout your intestines due to a bacterial infection of the intestinal tract that is highly contagious), Malignant neoplasm of unspecified part of unspecified bronchus or lung, Secondary malignant neoplasm of brain, and secondary malignant neoplasm of skin. On 7/17/24 Surveyors reviewed R1's medical record and infection control line list for June 2024. R1's After Visit Summary for hospitalization dates from 6/12/24 to 6/20/24 indicate the following under Take These Medications: Start Vancomycin (antibiotic) 125mg Cap - Take 1 capsule by mouth 4 times a day for 8 days for: Infectious Diarrhea, C. Diff. Last time this was given: 125mg on June 20, 2024 9:30AM . Surveyors found no evidence that R1 was placed on isolation for C. diff infection on admission to the facility. On 7/17/24 at 1:21PM, Surveyor interviewed RN D (Registered Nurse) regarding R1's admission to the facility and isolation for C. diff. RN D indicated during the interview that she was the nurse that began R1's admission process. RN D indicated it was at change of shift and hospice was also present trying to admit R1 to their service. RN D indicated she was not able to complete the entire admission process and the next shift was supposed to finish. RN D indicated R1 was not put on isolation for C. diff at that time. RN D indicated she was off the weekend and came back on Monday (6/24/24) and noted R1 was on oral Vancomycin. RN D called the NP (Nurse Practitioner) and placed R1 on isolation for C. diff that morning. RN D indicated she also spoke with the DON B (Director of Nursing) and told him about the oral vancomycin order and that the hospital notes indicated C. diff. (continued on next page)

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	07/17/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 2:49PM Surveyor interviewed DON B regarding R1's isolation for C. diff. DON B indicated during the interview that they had initiated enhanced barrier precautions due to R1 having a wound and a foley catheter (catheter to drain urine). DON B indicated R1 was not put on contact precautions for C. diff until a few days after admission when they realized she had the diagnosis. DON B indicated R1 should have been put on contact isolation on admission to the facility and was not.