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	10/17/2024

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 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** 36253 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 for 1 of 15 residents (R2) reviewed for abuse. On 8/2/24, the facility became aware of an allegation of abuse by a Certified Nursing Assistant to a resident and did not conduct a thorough investigation. Findings include. The facility's policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property states, Investigation of abuse: When an incident or suspected incident of abuse is reported, the Executive or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include i.) Who was involved ii.) Residents' statements, iii.) Resident's roommate statements (if applicable), iv.) Involved staff and witness statements of events . Additionally, the policy goes on to state, It is the policy of this facility that the resident(s) will be protected from the alleged offender(s). Immediately upon receiving a report of alleged abuse, the Executive Director, and or designee will coordinate delivery of appropriate medical and/or psychological care and attention. Ensuring safety and well-being for the vulnerable resident are of utmost priority. Safety, security and support of the resident, their roommate, if applicable, and other residents with the potential to be affected will be provided .the alleged perpetrator will immediately be removed, and resident protected. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation. R2 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), dated [DATE], includes a Brief Interview for Mental Status (BIMS) score of 13, indicating R2 is cognitively intact. (continued on next page)

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
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/24, the facility became aware of an allegation of abuse between a Certified Nursing Assistant (CNA) and resident and began an investigation. During the investigative process, the facility conducted interviews of residents and staff, beginning on 8/2/24. Questions for residents involved safety at the facility, if any staff touched residents inappropriately, and if residents had any care concerns with any staff. Staff questions involved observations or concerns with fell ow staff and their treatment and care of residents. When R2 was interviewed, she was asked if she felt safe at the facility. R2's response stated on 8/1/24 a CNA had come into her room to bring her meal tray and, due to R2's over-the-bed table being covered with personal items, the CNA said, There's no place to put the tray, you dumb f**k. R2 did not know the name of the CNA but provided a description. The description and alleged date of the incident assisted the facility in preliminarily identifying CNA C as the potential perpetrator (not the alleged perpetrator that initiated the investigation). The facility suspended CNA C on 8/2/24 while continuing the investigation, however, the facility allowed CNA C to return to the facility on [DATE]. The facility did not finish conducting the investigation until 8/6/24. R2 was interviewed again on 8/5/24 and is documented as being fuzzy on occurrence. The facility did not have a statement from CNA C regarding the initial allegation of abuse or the allegation against her. In the facility's summary of the incident involving R2, NHA D (Nursing Home Administrator), who no longer works at the facility, documented the following: *It was discovered CNA C was not clocked in on 8/2/24 *Interviews with a CNA indicated CNA C was not in the building on 8/1/24 and on 8/2/24 CNA C was in the dining room assisting residents. *CNA C was told she could return to work on 8/3/24 by NHA D. NHA D requested that CNA C not take care of R2 until further notice, or to have another nursing staff with her. Facility-provided timesheet documentation shows CNA C worked in the facility on 8/1/24, 8/2/24, 8/3/24, and 8/4/24. On 10/8/24 at 2:03 PM, Surveyor interviewed DON B (Director of Nursing). When asked why CNA C was allowed back into the facility while the investigation was ongoing, DON B stated that perhaps they had enough information that CNA C could return to work. When asked if it were possible that between 8/3/24 when CNA C was allowed to return to work and 8/6/24 when the investigation was completed that additional resident or staff interviews could have revealed additional concerns regarding CNA C, DON B stated, It is possible. On 10/8/24 at 2:54 PM, Surveyor interviewed CNC E (Clinical Nurse Consultant) who stated that she contacted NHA D who stated that she (NHA D) did not have a statement for CNA C and that her return to work so soon after the allegation was due to the belief that CNA C had not passed room trays on 8/1/24. When asked if there were any additional interviews regarding who passed room trays on or around 8/1/24 or information identifying who may have been in R2's room around various mealtimes, CNC E stated there was not, but she would get a statement from CNA C. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was aware of an allegation of abuse and did not protect residents while the investigation was ongoing and did not interview/gather a statement from the alleged staff (CNA C) to help identify any additional potential perpetrators and/or victims.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice when experiencing a change in condition for 2 of 4 sampled residents (R7 and R8). R7 had a change in condition on 6/22/24. R7 has diabetes mellitus type 2. The facility has not completed daily diabetic foot checks, assessed, nor measured R7's diabetic wound, described the wound bed or continuously monitored R7's wound. In addition, R7's provider was not updated. R7 was sent to the hospital on 6/27/24 for osteomyelitis of the right second toe. Subsequently, R7's right second toe was amputated on 6/28/24. R7 developed a new diabetic wound that worsened and became infected with MRSA (Methicillin-Resistant Staphylococcus Aureus), Corynebacterium Striatum, Pseudomonas aeruginosa, and Enterococcus Faecalis; MRSA and Corynebacterium Striatum are life-threatening Multidrug-Resistant Organisms (MDRO). Staff failed to measure and assess R7's wound weekly, failed to contact a Physician/NP (Nurse Practitioner) timely, failed to complete wound treatments and failed to implement aggressive preventative measures to prevent R7's wound from deteriorating/worsening. These failures created a finding of immediate jeopardy that began on 6/22/24. NHA A (Nursing Home Administrator) was notifed of the immediate jeopardy on 10/10/24 at 12:35 PM. The immediate jeopardy was removed on 10/10/24 and continues at a severity/scope level of G (actual harm/isolated) as evidenced by the following: R8 received a burn on his foot from Tea Tree Oil after a nurse completed the treatment incorrectly placing undiluted Tea Tree Oil directly on R8's foot. The facility did not complete weekly assessment per standards of practice. R8's wound became infected requiring antibiotics. As evidenced by: The facility policy, Standard Diabetes Mellitus Protocol, undated, indicates, in part, as follows: Problem: Patient has potential for fluctuating blood sugar and/or complications of diabetes mellitus. Goal: Patient will: 1) remain compliant with diet 2) blood sugars to be within parameters as determined by the physician orders 3) exhibit no hypo/hyperglycemia episodes. Complete daily foot checks; Update physician and responsible party as needed, check blood sugars/labs as ordered. The facility policy, Pressure Injury Prevention and Managing Skin Integrity, reviewed 8/10/23, indicates, in part, as follows: Weekly Wound Rounds: a. Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds. b. Registered Nurse (RN) or designee will: i. Conduct weekly skin evaluation, ii. Update the PCP (Primary Care Provider) with any decline in wound appearance, or as necessary. iii. Update the care plan with interventions as applicable. Administrative Review a. Interdisciplinary Team (IDT) reviews Pressure Ulcer/Abnormal Skin Findings through Quality Assurance Committee. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7 was admitted to the facility on [DATE] with diagnoses including, but not limited to, diabetes mellitus type 2, neuropathy, BKA (below the knee amputation) to LLE (left lower extremity) on 12/16/22, toe amputation to right foot (7/28/21), peripheral arterial disease, phantom limb pain, history of MRSA (Methicillin-Resistant Staphylococcus Aureus) (unclear source), and Chronic Kidney Disease Stage 3b. R7's Admission Minimum Data Set (MDS) dated [DATE] indicates R7 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. R1's MDS indicates he is at risk for skin impairment and was admitted with no skin impairment. R7's Certified Nursing Assistant (CNA) Kardex, dated 10/8/24, documents the following: Skin Integrity Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length x width x depth), stage. R7's Progress Notes: On 6/10/2 at 10:25 PM, LPN O (Licensed Practical Nurse) documents, in part, the following: Rt (right) leg/foot noted with redness and weeping to the top of R foot cleansed with NS and wrapped with kerlix. On 6/11/24 9:45 PM, LPN O documents the following: Resident in w/c (wheelchair) started on PO (oral)/ABT (antibiotic)/Cellulitis/Rt Foot (right) with CDI (clean, dry, intact) T97.6 no adverse reaction noted. On 6/11/24, R7 was started on Cedfinir oral capsule 300 mg Give 1 capsule 2x/d for cellulitis for 10 days for right foot cellulitis. Note, Cefdinir is an antibiotic used to treat bacterial infections. On 6/12/24 at 11:59 PM, LPN O documents the following: Resident A/O x4 (Alert and Oriented) remains on PO/ABT/Tx/Cellulitis Leg with CDI dressing. T98.9 no adverse reaction noted. On 6/15/24 at 1:37 PM, LPN O documents the following: Resident up in w/c A/O/4 remains on PO/ABT/Cellulitis Rt Foot Red and dry no wheeping [SIC] noted Tx applied per MD (Medical Doctor) order tolerated well T-97.9 On 6/15/24 at 8:53 PM, LPN O documents the following: Resident remains on PO/ABT/Rt Leg infection no adverse reaction noted T98.7 Tx done per MD order tolerated it well. T97.9 On 6/16/24 at 11:49 AM, Resident remains on PO/ABT/TX no adverse reaction noted T97.6 Rt Foot Tx done tolerated it well to Rt Foot. On 6/17/24 at 10:11 PM, LPN O documents the following: Resident remains on PO/ABT/Tx/Lft [SIC] Leg Cellulitis no adverse reaction noted T97.6 Rt Foot Tx applied after Shower Foot very Red and Moist tolerated Tx well. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7 has an order for Mupirocin oint (ointment) 2% (Used to treat bacterial skin infections or staph) apply followed by ABD (dressing) and wrap with kerlix. The facility did not complete a total of ten (10) treatments on the following dates: 6/10/24, 6/12/24, 6/17/24, 6/19-6/22/24, 6/24-6/26/24; note there are no measurements or indication why the facility is using this. On 6/17/24, R7's Weekly skin check is blank. On 6/22/24 at 5:22 AM, LPN O documents as follows: Tx done per MD order to Rt Foot and Buttock both draining very much with foul order [SIC] and large amount of [NAME] drainage advised to keep leg elevated and take a break from sitting up in the W/C (wheel chair) resident is very non-compliant was also told that on PM shift as well but didn't listen. T97.8 It is important to note, there is no update to the provider, no measurement, or wound assessment. On 10/9/24 at 11:45 AM, Surveyor called LPN O (Licensed Practical Nurse). LPN O did not return Surveyor's call. On 6/24/24 at 1:30 PM, NP Q (Nurse Practitioner) documents the following: Chief Complaint: seen for follow up diffuse rash x 3 days R7 was seen resting in bed. He is seen for diffuse rash to upper torso, arms, legs, groin. He has increased edema to bilateral thighs as well as redness to bilateral groin. He was treated with Diflucan as well as nystatin cream with little improvement for intertrigo (a rash that appears between the folds of skin). He does have a diagnosis of T2DM (Diabetes Mellitus Type 2), but unable to see blood glucose monitoring. Will add Bumex (a diuretic to decrease fluid), will update A1C (blood glucose monitoring over 3 months), update labs, will add prednisone, continue Benadryl. Facility staff made aware of plan of care. Continue wound care with [NAME] [SIC], encourage to shower three times weekly if possible, patient agrees with POC (Plan of Care). Skin - no masses, no rashes, no lesion on exposed skin, PVD (peripheral vascular disease) skin change to RLE (right lower extremity) . Of note, NP Q is no longer employed with clinic and instructed the facility to not contact her. On 10/9/24 at 1:35 PM, Surveyor contacted NP Q (Nurse Practitioner). NP Q did not return Surveyor's call. On 6/24/24, R7's Weekly skin check is blank. On 6/24/24 at 10:21 PM, LPN O documents, in part, the following: Skin Evaluation: Skin warm & dry, skin color WNL (within normal limits), mucous membranes moist, turgor normal. Resident has current skin issues. Skin tissue: Open lesion (other than ulcers, rashes and cuts). Skin issue location .Infection of the foot. Skin issue location: Rt Foot Wound bed: Granulation. Wound exudate: Purulent. Per wound condition: Maceration. Dressing saturation: Heavy (75%). Wound odor: Yes. Tissue: Cool. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note: .Cellulitis to Rt Foot Note: Provider not updated, no indication of what the wound looks like or being updated on the odor or drainage. On 6/25/24 at 10:30 PM, LPN O document the following: Resident in recliner with leg elevated on a pillow with CDI (Clean, dry and intact) dressing to Rt Foot. On 6/27/24 at 4:47 AM, Physician/Med Dir R (Physician/Medical Director) conducted a visit at the facility. Physician/Med Dir R documents the following: Reason: Physician Monthly Follow-up Visit Type: SNF (Skilled Nursing Facility) Monthly Compliance Subjective: Patient seen today for multiple chronic conditions. Laying in bed no fever, chills, nausea, vomit, chest pain or chest tightness. Has a diffuse rash for which he was started on prednisone. It has been pruritic (itchy skin) but it seems to be improving as well. He does have some flaky skin and thus was started on Aquaphor as well. Care discussed with nursing staff. Physical Exam - General-no acute distress, comfortable Extremities-left below the knee amputation, right lower extremity dressing Phantom limb syndrome Type 2 diabetes mellitus with foot ulcer. Continue with current plan of care, monitor blood sugars, avoid hypoglycemia. Followed by wound care as well. It is important to note, this MD (Medical Doctor) note is for monthly compliance. The note indicates, right lower extremity dressing and Type 2 diabetes mellitus with foot ulcer. MD/Med Dir R's note does not indicate if Physician/Med Dir assessed or looked at R7's wound, or if he was aware that there was purulent drainage or an odor. On 6/27/24 at 6:53 AM, Physician S, a traveling wound physician, documented the first assessment and measurements for R7's wound. Non-Pressure wound of the Right, second toe Full Thickness Etiology (quality): Undetermined/Unknown Further Etiology Detail unclear of how wound developed per patient Duration: >1 day Objective: Healing/Maintain Healing Wound Size (L x W x D): 1.3 x 1.3 x 0.1 cm (centimeter) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surface Area: 1.69 cm2 Exudate: Moderate Sero-sanguinous Granulation Tissue: 60% Other viable tissues: 40% (Bone, Cartilage) Additional Wound Detail: bone/joint exposed in appearing toe fracture with surrounding cellulitis, unclear etiology of wound and onset and whether surrounding cellulitis is indicative of superficial vs deep (bone) involvement. Expanded Evaluation Performed: .Patient requiring an increase in the level of care, recommend sending patient to ED (emergency department) given toe wound with bone exposed with surrounding cellulitis, unknown duration of wound given cellulitis and bone exposure reccomend ED (emergency department) eval for abx (antibiotics) and possible amp (amputation). On 6/27/24, R7 was immediately sent to the ED following Physician S's assessment. R7's second (2nd) toe on his right foot was amputated on 6/28/24. On 6/27/24 at 8:14 AM. The facility notified the clinic (name) regarding resident bone/joint exposed in appearing toe fracture with surrounding cellulitis, unclear etiology of wound and onset and whether surrounding cellulitis is indicative of superficial vs deep (bone) involvement. Resident sent to Hospital ED. R7's hospital report documents the following: Chief complaint exposed bone, R (right) foot exposed bone - cefepime and vanco (intravenous antibiotics) given in ER - (ended up with [NAME] syndrome from vanco) - No s/sx (sign/symptoms) systemic infection. HX MRSA (Methicillin-Resistant Staphylococcus Aureus) and CKD (Chronic Kidney Disease) stg (stage) 3. R7 was hospitalized ,d+[DATE] - 7/2/24. (5 days) R7's Hospital Report documents the following: Admission Dx (Diagnosis): Injury of toe on right foot, initial encounter. Reason for hospitalization : Development of new ulcer with exposed bone wound of second toe on right foot. Significant Findings: Osteomyelitis of the second right toe Patient Course & Care: .R7 was sent for admission due to wound of his second right toe which looked infected. He was admitted and started on IV (intravenous) antibiotics and podiatry was consulted. Decision was made to do the toe amputation which was done. Infectious diseases was consulted and made long-term antibiotic recommendations. He was able to discharge back to his SNF (Skilled Nursing Facility) and receive his IV antibiotics they are to follow-up with podiatry and infectious diseases. PRINCIPAL/FINAL DIAGNOSES: Osteomyelitis right second toe (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/1/24, R7 was seen by Infectious Disease. The report documents the following: Reason for follow up right foot secondary to osteomyelitis. Surgical cx (culture) distal portion of amp (amputation) 6/28/24 - MRSA (Methicillin-Resistant Staphylococcus Aureus); Pseudomonas aeruginosa, Corynebacterium Striatum. It is important to note, MRSA and Corynebacterium Striatum are both life-threatening Multidrug-Resistant Organisms (MDROs). Surgical cx (culture) proximal amp/bone 6/28/24: E. Faecalis (Enterococcus Faecalis); Corynebacterium Striatum Visit Diagnosis: Acute osteomyelitis of Right Foot On 10/7/24 at 11:45 AM, Surveyor spoke with R7. Surveyor asked R7 regarding the right second toe that was amputated. Surveyor asked R7 how the wound occurred. R7 stated he is unsure how the wound occurred; however, he may have stubbed or bumped it on something. Surveyor asked R7, is there anything that staff did to cause the wound. R7 stated, No. On 10/9/24 at approximately 12:00 PM Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, do you expect medication to be administered per physician orders. DON B stated, Yes. Surveyor shared R7's order for Muprocin ointment: Muprocin oint (ointment) 2% (Used to treat bacterial skin infections or staph) apply followed by ABD and wrap with kerlix. Surveyor asked DON B, do you expect R7's Muprocin (an antibiotic)/treatment to be completed per physician orders. DON B stated, Yes. Surveyor shared with DON B that R7's Muprocin/treatment was not completed on the following dates: 6/10, 6/12, 6/17, 6/19-6/22 and 6/24-6/26. Surveyor asked DON B, should R7 have received Muprocin/treatment per physician orders. DON B stated, Yes. Surveyor asked DON B, did the facility identify that Cefdinir/treatment was not completed per physician orders. DON B stated, no. Surveyor shared LPN O's progress note on 6/22/24 that documents R7's toe was Draining very much with foul odor and Large amount of green drainage. Surveyor asked DON B if he sees documentation that the provider was notified. DON B reviewed R7's medical record for documentation. DON B stated, he does not see documentation that R7's provider was notified on this date (6/22/24) or any day prior to R7 being sent to the ED (emergency department). Surveyor asked DON B, should LPN O have notified the provider regarding Draining very much with foul odor and Large amount of green drainage. DON B stated, Yes. Surveyor asked DON B, how often should diabetic foot checks be done. DON B stated, Daily. Surveyor asked DON B, why is it important that this is completed daily. DON B stated, so we can catch things early so they don't become problematic later on. DON B added, We don't want a delay in care for our residents. Surveyor asked DON B, do you expect daily diabetic foot checks to be completed for diabetic residents. DON B stated, I would, yes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor stated, R7's weekly skin assessments are not completed on 6/17/24 and 6/24/24. Surveyor asked DON B, should staff have completed R7's weekly skin assessments on 6/17/24 and 6/24/24. DON B stated, Yes. Surveyor asked DON B, are any staff WCC (Wound Care Certified) staff. DON B stated, No, nobody has the credentials. Surveyor asked DON B, do you expect staff to assess and measure wounds. DON B stated, yes. DON B stated, A description of some sort should happen. DON B stated, he normally leaves wound measurements up to the wound care physician. Surveyor asked DON B, how often should wounds be measured. DON B stated, Weekly. On 10/9/24 at approximately 1:00 PM, Surveyor observed R7's amputation site is healed. On 10/9/24 at 4:05 PM, Surveyor spoke with PA P (Physician Assistant). Surveyor shared with PA P that the facility is not completing daily diabetic foot checks for R7. Surveyor asked PA P, would you expect the facility to be completing daily diabetic foot checks. PA P stated, Yes. Surveyor shared LPN O's (Licensed Practical Nurse) progress note from 6/22/24 documenting R7's toe wound as Draining very much with foul odor and Large amount of green drainage. Surveyor asked PA P, would you expect to be notified. PA P stated, Yes, absolutely in a situation like that. Surveyor asked PA P, how soon would you expect to be notified. PA P stated, Immediately upon finding this and Don't delay, even 1 hour. PA P checked the clinic records and stated on 6/22/24 there is no note that a provider was updated by the facility. PA P added, on 6/24/24 there was a follow up for a rash and no indication of the toe. Surveyor asked PA P, do you expect the facility to administer medications and treatments per provider orders. PA P stated, Yes, absolutely. The facility's failure to complete daily diabetic foot checks, assess, measure, and describe wound beds weekly, continuously monitor R7's wound, and notify R7's provider when the wound has deteriorated resulted in R7 being sent hospital on 6/27/24 for osteomyelitis of the right second toe. Subsequently, R7's right second toe was amputated on 6/28/24. This created a finding of immediate jeopardy which was removed on 10/10/24 when the facility completed the following: 1. Skin sweep of entire facility completed 10/10/2024 2. Sweep of all active treatment orders completed for accuracy done 10/10/2024. 3. All residents with DM have daily foot checks added to TAR. done 10/10/2024 4. Education will be mandatory for all nurses and CNA prior to next working shift including: DM foot care with completing daily diabetic foot checks; skin change observation expectations are that CNA report all skin changes immediately to the nurse; provider notification and change of conditions expectations are that nurses will report all diabetic foot ulcers, redness, purulence, drainage to physician; weekly wound assessments with measurements;and treatments completed as ordered. Starting 10/10/24 pm shift thru all staff completion. Monitoring, Audits, QAPI, and Facility Assessment 1. DON or designee will ensure DM foot checks done daily X 14, weekly x 4 and monthly x 2 bringing results to QAPI. (continued on next page)

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	525639	A. Building B. Wing	10/17/2024

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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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. DON or designee will ensure weekly skin checks are completed daily x 14, weekly X 4 and monthly X 2 bringing results to QAPI. 3. DON or designee will ensure weekly skin documentation completed during wound rounds; weekly X 6 and monthly x 2 bringing results to QAPI. 4. DON or designee will audit wound care treatments two residents weekly X 6, monthly x 2 bringing results to QAPI. 5. Clinical Nurse Consultant will audit process of PCC documentation / 24 hour board follow up weekly x 6 and monthly X 2 to ensure changes of condition have needed follow up completed. Example 2 R8 was admitted to the facility 7/23/24 with diagnoses including, but not limited to, as follows: diabetes mellitus type 2, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, non-pressure chronic ulcer of the left foot, cellulitis of left lower limb, muscle weakness, lack of coordination, cramp and spasm. R8's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R8 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. R1's MDS indicates he does not have current venous or arterial ulcers. On 3/5/24 Physician/Med Dir R (Physician/Medical Director) ordered the following treatment: 3 drops of Tea Tree oil per ounce of water to soak left great toe three times a week. Every evening shift every Tue, Thu, Sat for fungal treatment of Left great toe. (It is important to note, Physician/Med Dir R (Physician/Medical Director) ordered the Tea Tree oil to be diluted and not applied directly to or under the the toenail.) On 4/4/24 R8's Weekly Skin Check indicates no areas of concern. On 4/24/24 R8's Weekly Skin Check indicates No skin issues. On 4/20 or 4/28/24, per interview with DON B (Director of Nursing) R8 reported to DON B (Director of Nursing) the second digit on his left foot was burning. DON B stated, he assessed the area and did not see anything. DON B stated, he thought this burning pain may be from neuropathy. DON B stated, R8's skin was intact with no redness. DON B did not document this encounter. DON B stated, this occurred when he was working the floor on a PM shift and completed R8's Tea Tree oil treatment. On 5/1/24, R8's Weekly Skin Check indicates the previous ADON (Assistant Director of Nursing; no longer employed at the facility) circled R8's feet and initiated; no additional information is provided. No areas of concern are documented on the Skin Check or Progress Notes. On 5/6/24 at 4:42 PM, updated by ADON (previous) on open area to Left foot/toe 2.0 cm x 0.4 cm x 0.3 cm. Great toe and next 2nd toe S/S (signs/symptoms) of infection, minimal drainage, redness and increased pain to area. New orders received: Culture wound prior to start of ABX (antibiotic) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start on Cefdinir 300 mg PO (by mouth) BID x 10 days Tx (Treatment): Cleanse Left foot with wound cleanser and apply non-adhesive dressing Daily x 10 days. Monitor S/S infection daily. On 5/6/24 at 5:52 PM, a Registered Nurse documented the following: Cx (culture) to Left toe obtained and sent to (hospital name) by Assistant Director of Nursing (prior), Tx (treatment) completed post cx (culture) by RN. Resident toes on left foot very sensitive. ABD applied to top of Telfa for protection. Physician S, a wound physician, completed the following wound assessments. 5/9/24 (Initial assessment) Exam - Peripheral Vascular: Examination of left lower extremities. Mild edema, foot warm, wound present. See Focused Wound Exam below. Examination of right lower extremities: Mild edema, foot warm Pedal pulses left .Dorsalis Pedis Monophasic Signal Detected by Portable Doppler Pedal pulses right .Dorsalis Pedis Monophasic Signal Detected by Portable Doppler Focused Wound Exam: Chief complaint: Patient present with a wound on his left foot. Focused Wound Exam: Burn Wound of The Left Foot Full Thickness Etiology: Burn Duration: > (greater than) 7 days Objective: Healing/Maintain Healing Wound Size: 1.5 x 0.5 x Not measurable cm (centimeters) Depth is unmeasurable due to presence of nonviable tissue and necrosis. Surface Area: 0.75 cm2 Exudate: Light Sero-sanguinous Thick adherent devitalized necrotic tissue: 30% Granulation Tissue: 70% (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/16/24 .Focused Wound Exam: Burn Wound of The Left Foot Full Thickness Etiology: Burn Duration: > (greater than) 14 days Objective: Healing/Maintain Healing Wound Size: 1.5 x 0.5 x 0.1 cm (centimeters) Surface Area: 0.75 cm2 Exudate: Light Sero-sanguineous Thick adherent devitalized necrotic tissue: 30% Granulation Tissue: 70% Wound Progress: Not at goal 5/23/24 .Peripheral Vascular Focused Wound Exam: Burn Wound of The Left Foot Full Thickness Etiology: Burn Duration: > (greater than) 21 days Objective: Healing/Maintain Healing Wound Size: 1.3 x 0.5 x 0.1 cm (centimeters) Surface Area: 0.65 cm2 Exudate: Light Sero-sanguineous Granulation Tissue: 100% (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Expanded Evaluation Performed: .The patient's advancing peripheral arterial disease/gangrene significantly increases their susceptibility to complications and poor prognosis. Patient with L (left) SFA (Superficial femoral artery) occlusion with distal region to popiteal. PT (Physical Therapy and DP (Doctor of Podiatry) referral to vascular surgery for revascularize discussion with angio with PTA (angiogram with percutaneous transluminal angioplasty is a procedure that combines an angiogram with an interventional procedure to open a blocked or narrowed artery. PTA is a minimally invasive procedure that involves inserting a catheter with a balloon into an artery to widen it and improve blood flow.) vs operative planing for possible distal bypass target given delayed wound healing from his injury. Wound Progress: Improved evidence by decreased surface area 5/30/24 .Focused Wound Exam: Burn Wound of The Left Foot Full Thickness Etiology: Burn Duration: > (greater than) 28 days Objective: Healing/Maintain Healing Wound Size: 1.4 x 0.7 x 0.1 cm (centimeters) Surface Area: 0.98 cm2 Exudate: Light Sero-sanguineous Granulation Tissue: 100% Wound progress: Not at goal 6/6/24 .Focused Wound Exam: Burn Wound of The Left Foot Full Thickness Etiology: Burn Duration: > (greater than) 35 days Objective: Healing/Maintain Healing Wound Size: 1.2 x 0.6 x 0.1 cm (centimeters) Surface Area: 0.72 cm2 Exudate: Light Sero-sanguineous (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Granulation Tissue: 100% Wound Progress: Improved evidence by decreased surface area 6/13/24 .Focused Wound Exam: Burn Wound of The Left Foot Full Thickness Etiology: Burn Duration: > (greater than) 42 days Objective: Healing/Maintain Healing Wound Size: 1.0 x 0.7 x 0.1 cm (centimeters) Surface Area: 0.70 cm2 Exudate: Light Sero-sanguineous Granulation Tissue: 100% Wound progress: Improved evidence by decreased surface area Dressing Treatment Plan: Primary Dressing(s): Silver sulfadiazine apply once [NAME] for 23 days. Secondary dressing(s): Telfa apply once daily for 23 days. Gauze roll (kerlix) 2.25 (inch) apply once daily for 23 days. 6/27/24 .Focused Wound Exam: Burn Wound of The Left Foot Full Thickness (*Note, the facility went 14 days in between wound assessments and measurements. The wound worsened and is now 50% slough. The facility did not notify Physician S that R8's wound worsened. Physician S assessed R8 for a routine wound care visit and noted R8's change in condition.) Etiology: Burn Duration: > (greater than) 56 days Objective: Healing/Maintain Healing Wound Size: 1.5 x 1.5 x 0.1 cm (centimeters) Surface Area: 2.25 cm2 Exudate: Light Sero-sanguineous (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Slough: 50% Granulation Tissue: 50% Wound progress: Not a goal Dressing Treatment Plan: Primary Dressing(s): Santyl apply once daily for 30 days; Alginate calcium with silver apply once daily for 30 days: silver will not inactivate santyl Secondary Dressing: Gauze island with bdr (border) apply once daily for 30 days Reason for no sharp debridement: Debridement not indicated secondary to severe peripheral arterial disease 7/4/23 .Focused Wound Exam: Burn Wound of The Left Foot Full Thickness Etiology: Burn Duration: > (greater than) 63 days Objective: Healing/Maintain Healing Wound Size: 1.7 x 1.5 x 0.1 cm (centimeters) Surface Area: 2.55 cm2 Exudate: Light Sero-sanguineous Slough: 30% Granulation Tissue: 70% Wound progress: Not a goal Dressing Treatment Plan: Santyl apply once daily for 23 days; Alginate calcium with silver apply once daily for 23 days: silver will not inactivate santyl Secondary Dressing: Gauze island with bdr (border) apply once daily for 23 days Reason for no sharp Debridement: Debridement not indicated secondary to severe peripheral arterial disease Investigations: Recommended And/Or Reviewed: X-ray recommended on left D2 (digit 2/2nd toe) R/O (rule out) OM (osteomyelitis) on 7/4/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/4/24 Physician S wrote the following new order: Doxycycline 100 mg (milligrams) BID (two times a day)x 14 days stop 7/18/24. pre-medicate prior to dressing changes given patient's pain with change and following to minimize patient refusal of care due to pain. *7/11/24 .Focused Wound Exam: Burn Wound of The Left Foot Full Thickness Etiology: Burn Duration: > (greater than) 70 days Objective: Healing/Maintain Healing Wound Size: 1.7 x 1.5 x 0.1 cm (centimeters) Surface Area: 2.55 cm2 Exudate: Light Sero-sanguineous Slough: 30% Granulation Tissue: 70% Wound progress: Not a goal Expanded Evaluation Performed: .The patient's advancing peripheral arterial disease/gangrene significantly increases their susceptibility to complications and poor prognosis, patient with PAD (peripheral arterial disease), have previously recommended vasc (vascular) studies and PVS (an ultrasound for Peripheral Vascular Disease) given nonhealing wound in setting of PAD (Peripheral Arterial Disease). MRI (Magnetic Resonance Imaging) ordered for definitive eval of possible underlying OM (osteomyelitis), patient will require sedation to perform as prior attempt unsuccessful. On 7/11/24, Physician S documented the following Progress Note: Patient with erythema surrounding wound site despite ongoing Doxycycline therapy, patient scheduled to see pcp (primary care physician) for clearance or MRI however given this erythema despite abx (antibiotic) patient would likely require hosp (hospital) admission for broadspec (broadspectrum) abx (antibiotic) and expidited workup for OM and intervention (revasc if possible) +1 amp. R8 was hospitalized from 7/11-7/23/24. On 7/18/24, Physician S's documented the following Progress Note: The patient's visit has been rescheduled, patient remains in hospital s/p (status post) LE (left extremity) stent placement. IV abx (antibiotics) R8's hospitalization documents the following: Chief Complaint: Toe necrosis/cellulitis (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Patient with worsening necrosis of his foot and some spreading cellulitis appearance. He had been on Doxycycline and followed closely by wound care in the outpatient setting. he has since been put on Cefepime and vancomycin under the direction of the infectious disease team. With evaluation by local podiatry they did not feel like they could definitely amputate the involved toe without knowing more about his vasculature. Apparently there is inability to get CT angiogram for a number of days locally. He is being brought up to facilitate the workup here with vascular evaluation and CT angiogram imaging. At the time of my evaluation he describes just the discomfort in his left second digit as noted. No new areas of discomfort. Feels like the erythema in his leg is improving. Physical Exam: Extremities: Some degraded tissue on the left second digit with some other surrounding erythema, the erythema up his foot to his is receding. Circulation: Radial, pedal pulses are intact and symmetrical Assessment and Plan Infected diabetic left foot ulcer Possible Left 2nd toe OM (osteomyelitis) Cellulitis Culture from 7/11/24 growing pseudomonas/MRSA (Methicillin-Resistant Staphylococcus Aureus) ID (Infectious Disease) consulted, appreciate recs - vanco (vancomycin), cefepime, metronidazole (intravenous antibiotics), continue on discharge, ordered per ID. He will need a 6 week course of IV (intravenous) antibiotic therapy, day 0 of therapy is 7/12/24. Surveillance labs while on IV antibiotic therapy to include weekly CBC (Complete Blood Count) with differential, creatinine, ALT (Alanine aminotransferase), and vancomycin trough (tests level of vancomycin in the bloodstream), and every other week CRP (C-Reactive Protein). Podiatry consulted, recs appreciated - underwent soft debridement, patient unable to tolerate sharp debridement PAD (Peripheral Arterial Disease) CT angiogram (medical imaging) showing significant PAD (Peripheral Arterial Diease). Vascular surgery spoke with patient and will perform an angiogram on 7/15. PT/OT (Physical T [TRUNCATED]

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on record review and interview, the facility did not ensure that 4 of 4 sampled residents (R7, R8, R1, and R15) received treatment and care in accordance with professional standards of practice for foot care. The facility failed to ensure daily diabetic foot checks were completed for R7, R8, R1, and R15. As evidenced by: The facility policy Standard Diabetes Mellitus Protocol, undated, indicates in part as follows: Problem: Patient has potential for fluctuating blood sugar and/or complications of diabetes mellitus.Complete daily foot checks. Example 1 R7 was admitted to the facility on [DATE] with diagnoses including, but not limited to, diabetes mellitus type 2, neuropathy, BKA (Below the Knee) amputation to LLE (left lower extremity) (12/16/22), toe amputation to right foot (7/28/21), peripheral arterial disease, phantom limb pain, history of MRSA (Methicillin-Resistant Staphylococcus Aureus) (unclear source), and Chronic Kidney Disease Stage 3b. Surveyor reviewed R7's medical record and current physician orders. The facility failed to ensure daily diabetic foot checks were completed for R7. Surveyor requested R7's daily diabetic foot checks and any documentation supporting this task. Facility did not provide any further documentation. Example 2 R8 was admitted to the facility 7/23/24 with diagnoses including, but not limited to, diabetes mellitus type 2, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, non-pressure chronic ulcer of the left foot, cellulitis of left lower limb, muscle weakness, lack of coordination, cramp, and spasm. Surveyor reviewed R8's medical record and current physician orders. The facility failed to ensure daily diabetic foot checks were completed for R8. Surveyor requested R8's daily diabetic foot checks and any documentation supporting this task. Facility did not provide any further documentation. On 10/9/24 at approximately 12:00 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, do you expect daily diabetic foot checks to be completed for diabetic residents? DON B stated, I would, yes. Surveyor asked DON B to review R7, R8, R1, and R15's medical record. Surveyor asked DON B, is there documentation to demonstrate the facility is completing daily diabetic foot checks for R7, R8, R1, and R15? DON B stated, no. Surveyor asked DON B, should daily diabetic foot checks be completed and documented for these residents as well as all diabetic residents? DON B stated, Yes. 44552 (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 3 R1 was admitted to the facility on [DATE] with diagnoses including respiratory failure, difficulty in walking, major depressive disorder, heart failure, dementia, and type 2 diabetes. Surveyor reviewed R1's MAR/TAR (Medication Administration Record/Treatment Administration Record) and current physician orders there is no evidence in R1's medical record to indicate daily diabetic foot checks were completed for R1. Example 4 R15 was admitted to the facility on [DATE] with diagnoses including cirrhosis of liver, kidney disease, and type 2 diabetes. Surveyor reviewed R15's MAR/TAR (Medication Administration Record/Treatment Administration Record) and current physician orders. There is no evidence in R15's medical record to indicate daily diabetic foot checks were completed for R15. Surveyor requested R15's daily diabetic foot checks and any documentation supporting this task. Facility did not provide any further documentation.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility did not ensure that a resident who enters the facility with an indwelling catheter receives appropriate treatment and services for 3 of 3 residents reviewed for indwelling catheters (R1, R11, and R14.) R1 has an indwelling urinary catheter, and his urine output is not being monitored. Additionally, R1 has a physician order for monthly catheter changes, which is not current standard of practice. R11 has an indwelling urinary catheter, and her urine output is not being monitored. Additionally, R11 has a physician order for monthly catheter changes, which is not current standard of practice. R14 has an indwelling urinary catheter and has active orders for two different sizes of foley catheter. This is evidenced by: Facility policy titled Bowel and Bladder - Catheter Care, dated 6/24/22, states in part: Policy: Nursing staff will assess catheter use to promote proper care. Procedure: A. Upon Admission or Insertion of Catheter . 2. Obtain Physician's Order including appropriate diagnoses/medical justification . C. Monitoring 1. Ongoing catheter use will be monitored for appropriate use and effectiveness . Facility policy titled Standard Indwelling Catheter Protocol, undated, states in part: Problem: Individual has Indwelling Catheter. Goal: Patency will be maintained, and risk of infection will be minimized. RN/LPN (Registered Nurse/Licensed Practice Nurse): . Change catheter/bag per CDC (Center for Disease Control) guidelines or as ordered by MD (Medical Doctor) . CNA (Certified Nursing Assistant): Provide perineal care am (morning) and pm (evening) shift and as needed . Empty drainage bag and document every shift in electronic record. Report urine characteristics to licensed nurse: odor, blood, lack of output, leaking around catheter, and individual urinary complaints . According to a CDC document with a revision date of 10/24/16: Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Example 1: R1 was admitted to the facility on [DATE] with diagnoses to include in part: Chronic Respiratory Failure with Hypercapnia (high levels of carbon dioxide in blood), Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, Hereditary and idiopathic Neuropathy (damaged nerves causing numbness or pain), Dementia, Neuromuscular Dysfunction of Bladder, Chronic Diastolic Heart Failure, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, and Retention of Urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/11/24, indicated that R1 has a Brief Interview for Mental Status (BIMS) of 14 out of 15 indicating that he is cognitively intact. Section H indicates that R1 is currently utilizing an indwelling catheter. R1's Comprehensive Care Plan states in part: [Resident Name] has an Indwelling Foley Catheter due to neurogenic bladder, potential for functional bowel incontinence. Has recent UTIs (urinary tract infections) . Interventions: CATHETER: care per MD orders . Monitor catheter patency, color, odor, etc. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD for s/sx (signs and symptoms) UTI . R1's Physician Orders state, in part: 20FR (French)/30cc (cubic centimeters) latex free catheter. Order date: 9/12/2024. Foley catheter-change as needed for occlusion or infection. Use latex Free Cath (catheter). Order date: 8/21/24. Foley catheter - change one time a day starting on the 21st and ending on the 21st every month for routine change. Use latex Free Cath. Order date: 8/21/24. Catheter care Q-shift (every shift) and prn (as needed) three times a day. Provide catheter care with warm damp cloth. Discontinue date: 8/7/24 at 9:06 AM. R1's Treatment Administration Record (TAR) indicates that his indwelling catheter was changed on 8/5/24, 8/21/24, 8/27/24, and 9/21/24. R1's TAR also indicates R1 missed 7 ordered catheter care treatments between 8/1/24 and 8/7/24. (Of note: R1's TAR does not contain any additional documentation of catheter care being performed every shift per policy, or any documentation of R1's urine output.) Example 2: R11 was admitted to the facility on [DATE] with diagnoses to include in part: Encounter for Palliative Care, Malignant Neoplasm of Left Female Breast, Multiple Sclerosis, Bipolar Disorder, and chronic kidney disease. R11's Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/29/24, indicates that R11 has a Brief Interview for Mental Status (BIMS) of 11 out of 15 indicating that she has moderate cognitive impairment. Section H indicates that R11 is currently utilizing an indwelling catheter. R11's Comprehensive Care Plan states in part: The resident has an Indwelling Catheter: Terminal Condition . Interventions: CATHETER: The resident has 16FR Foley Catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Monitor and document intake and output per facility policy. Monitor/record/report to MD for s/sx UTI . (Of note: Facility policy states urine output should be monitored once per shift.) (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Physician Orders state, in part: Catheter care three times a day. Provide catheter care. Start date: 8/22/24. Change drainage bag with Foley change and prn in the evening every 30 day(s). Date bag when changing. Start date: 8/22/24. Foley catheter - change q-30 days and prn as needed for occlusion or infection. Start date: 8/22/24. Indwelling foley catheter 16fr with 10cc balloon for comfort care. Order date: 8/22/24. No start date. Monitor Catheter Output every shift for output. Start date: 8/22/24. R11's Treatment Administration Record (TAR) indicates that her indwelling catheter was changed on 8/22/24, 9/21/24, and 9/28/24. Additionally, R11 did not receive catheter care on 8/27/24 in the AM (morning) and afternoon, on 9/6/24 in the AM and afternoon, on 9/10/24 in the AM and afternoon, on 9/11/24 in the AM and afternoon, on 9/16/24 in the AM and afternoon, on 9/20/24 in the afternoon, on 9/23/24 in the evening, and on 9/30/24 in the AM and afternoon. In October, R11 did not receive catheter care on 10/4/24 in the evening and did not receive any catheter care on 10/7/24. In total, from her admission on 8/22/24 through 10/8/24, R11 did not receive catheter care according to physician order and facility policy 18 times. (Of note: R11's TAR does not contain any documentation of R1's urine output.) Example 3 R14 was admitted to the facility on [DATE] with diagnoses to include in part: Dementia, degenerative disease of nervous system, Asthma, Epilepsy, Benign Prostatic Hyperplasia (BPH), and personal history of urinary (tract) infections. R14's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 9/19/24, indicates that R14 has a Brief Interview for Mental Status (BIMS) of 11 out of 15 indicating that he has moderate cognitive impairment. Section H indicates that R14 is currently utilizing an indwelling catheter. R14's Comprehensive Care Plan states in part: [Resident Name] has a foley catheter and functional/urge bowel incontinence and is at further risk r/t (related to) Dementia, need for assist with toileting, BPH with history of retention/catheter, Anxiety/Depression with psychotropic medication . Interventions: .Foley catheter care q (every) shift. Monitor output q shift . Monitor for signs of urinary retention due to catheter use and history . R14's Physician Orders state, in part: Change foley catheter q 30 days and prn 15th day. 16F (French) 10 cc balloon. In the evening every 1 month(s) starting on the 2nd for 1 day(s) for Benign Prostate Hyperplasia with obstruction. Start date: 9/2/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change foley catheter q 30 days. 16F 10 cc balloon. In the evening every 30 day(s) for Benign Prostatic Hyperplasia with obstruction. Start date: 9/2/24. Change foley catheter and bag every 4 weeks. 18Fr (French) 30cc one time a day starting on the 15th and ending on the 15th every month for Catheter change. Start date: 3/9/24. Flush foley catheter with 30 cc of normal saline q shift to prevent sediment build up per on call every shift related to BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMPTOMS (N40.1). Start date: 5/8/24. (Of note: R14's physician orders indicate he has active orders for two different sizes of indwelling catheters, 16FR and 18FR) R14's Treatment Administration Record (TAR) indicates that his indwelling catheter was changed on 8/13/24 and 9/12/24. On 10/8/24 at 9:36 AM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F who is responsible for measuring output from indwelling catheters. LPN F stated it is the CNAs' (Certified Nursing Assistant) responsibility, but the nurses will do it when they have time as well. Surveyor asked LPN F how often urine output should be measured and charted. LPN F stated every time it gets emptied. Surveyor asked LPN F where this information gets charted. LPN F stated in the electronic medical record and that there is no paper documentation. On 10/8/24 at 9:39 AM, Surveyor interviewed CNA N (Certified Nursing Assistant). Surveyor asked CNA N who is responsible for measuring output from indwelling catheters. CNA N states it is the CNAs' responsibility, but nurses will help if they have time. Surveyor asked CNA N how often she empties indwelling catheters. CNA N stated at least twice a day. CNA N also stated that only one of the residents in the facility with a catheter has orders placed for monitoring urine output. CNA N also stated that she has repeatedly advised nurses on PM (Evening) and NOC (Night) shifts as well as the DON (Director of Nursing) that these orders need to be added to the electronic medical record so that she can chart the output. CNA N states this has not been done yet for two of the residents. CNA N demonstrated charting in the electronic medical record for Surveyor, showing that only one resident with a catheter has an option to chart urine output. On 10/8/24 at 1:37 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked if DON B knew how many residents in his facility have a catheter. DON B stated, he believes there are three. Surveyor asked DON B what his expectations were for monitoring urine output for residents with catheters. DON B states that he expects urine output to be monitored every shift for residents with catheters. Surveyor asked DON B where he expects this information to be charted. DON B states there is a section to chart this information in (Electronic Medical Record), and that there is no paper documentation. Surveyor asked DON B if all residents with catheters should have urine output measured every shift. DON B states, yes, they should. Surveyor asked DON B regarding Foley catheter orders and if a resident has two orders for different sizes how the nurse would know which size to use. DON B stated the order should be clarified.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This has the potential to affect all 38 residents residing at the facility. Residents (R6 and R11) expressed long call light wait times due to not having enough staff. Staff voiced concerns with not being able to get tasks done due to not having enough staff per shift. Facility Scheduler indicated previous Administration directed Scheduler K to follow a grid that shows staff per resident ratio per shift. The grid does not take into consideration the acuity of the facility's resident population. The grid is currently being used to determine how to staff the facility. Evidenced by: The facility assessment titled Facility Wide Resource assessment dated ,d+[DATE], states, in part: . Introduction: The Facility Wide Resource Assessment is required by the nursing home requirements of participation to identify and analyze the facility's resident population and identify the personnel, physical plant, environmental and emergency response resources needed to competently care for the residents during day-to-day operations and emergencies .The Facility Assessment collects information about the facility's resident population to identify the number of residents; facility capacity; the care required; staff competencies; the ethnic; cultural and religious aspects of the unique resident population; physical; personnel resources needed; . Example 1: R6 was admitted to the facility on [DATE] with diagnoses including kidney disease, heart disease, depression, anxiety disorder, and osteoarthritis. R6's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/23/24, indicates R6 has a Brief Interview for Mental Status (BIMS) score of 14 indicating R6 is cognitively intact. R6 is her own person. On 10/7/24 at 10:30 AM, R6 indicated there are not enough staff at the facility. R6 indicated there are times that she must wait an hour for her call light to be answered due to the facility not having enough staff. R6 indicated there was a time that R6 had to wait an hour and a half for her call light to be answered. R6 indicated she was very upset and told staff this. R6 indicated it is usually the PM shift that call lights take a long time to be answered because the staff that are here are so busy. Example 2: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R11 was admitted to the facility on [DATE] with diagnoses including breast cancer, multiple sclerosis, and kidney disease. R11's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/29/24 indicates R11 has a Brief Interview of Mental Status (BIMS) score of 11 indicating R11 is moderately impaired. R11 is her person. On 10/7/24 at 11:15 AM, R11 indicated there are times she has to wait a long time for her call light to be answered. R11 indicated she has had to wait up to an hour. R11 indicated there are not enough staff working per shift and the staff that are here are overworked due to not having enough staff. R11 indicated staff know she is frustrated when this happens. R11 indicated right now she had asked to lay down and was told someone would be in R11's room in a minute. R11 indicated R11's bottom hurts and she has been waiting now for an hour. R11 indicated it takes a long time for assistance when there is shift change as well. On 10/7/24 at 11:37 AM, CNA J (Certified Nursing Assistant) indicated there have been issues with call-ins. There has been a lot of call-ins and new management is starting to hold staff accountable, previously this was not the case. CNA J indicated there are times tasks can't get done due to low staffing, but everyone tries to work together. On 10/7/24 at 3:55 PM, CNA M indicated there have been issues with call-ins and not having enough staff per shift. CNA M indicated there have been issues with not being able to get showers completed due to not having enough staff. On 10/7/24 at 4:05 PM, LPN O (Licensed Practical Nurse) indicated there are times that the facility has had one CNA on shift due to call-ins. LPN O indicated there are times that showers do not get done because of not having enough staff per shift. On 10/7/24 at 4:15 PM, CNA G indicated there are times that there is only one CNA on shift and a nurse. CNA G indicated there are times that there is one CNA because of call-ins, and it has been scheduled with only one as well. CNA G indicated she has worked NOC shifts where she couldn't get people up in the morning because of not having enough staff. CNA G indicated she felt like residents were not getting the care they need and were not getting assistance with being checked and changed because there was only one CNA. CNA G indicated everyone was complaining about the staffing. On 10/8/24 at 7:55 AM, MA H (Med Assistant) indicated there are tasks that do not get done due to not having enough staff on shift. MA H indicated showers, trays, water, and changing residents does not always get done due to not having enough staff on shift. On 10/8/24 at 8:55 AM, CNA I indicated the facility looks at the census and not acuity of the population of residents at the facility. CNA I indicated there has been times that she has worked at the facility being the only CNA due to call-ins. When this happens, she cannot get anyone up in the morning until AM shift comes in, showers and restorative cares do not always get done due to not having enough staff per shift. CNA I indicated she hopes staffing starts to get better with new administration. On 10/8/24 at 10:00 AM, CNA L indicated there have been times when there is only one CNA in the facility due to staffing. CNA L indicated charting does not always get done due to not having enough staff per shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/7/24 at 2:50 PM, Scheduler K (Scheduler) indicated she has been at the facility since April and picks up CNA hours as well. Scheduler K indicated she was directed by previous administrator to follow grid for staffing per shift. Scheduler K indicated the grid shows a census and then the number of CNAs and Nurses that the facility can staff per shift. Scheduler K indicated currently she tries to schedule 3 CNAs AM, 2.5 PM, and 2 on NOCs. Scheduler K indicated the previous administrator directed her to follow this grid. Scheduler K indicated, There's not enough staff here on each shift. I do hear this a lot from staff. Scheduler K indicated she currently is following this grid to staff shifts. Scheduler K indicated she will pick up shifts if there are call-ins or if she can't get shifts filled. Scheduler K indicated the grid does not take into account the acuity of the resident population. Scheduler K indicated another big issue was the previous administrator was taking all calls when there were call-ins, so Scheduler K didn't know when someone called in. On 10/8/24 at 8:00AM, NHA A (Nursing Home Administrator) indicated the grid that Scheduler K utilizes for staffing the facility does not take into consideration the acuity of the residents supported at the facility. NHA A indicated he has not seen the grid that Scheduler K uses and will ask another coworker if it is used throughout the organization. At 9:15 AM, NHA A indicated, Obviously I will adjust scheduling of the facility to include acuity of the residents. On 10/9/24 at 8:00 AM, DON B (Director of Nursing) indicated DON B had worked a lot of shifts throughout the summer. DON B indicated staffing was a concern over the summer because the facility was switching from agency to using own staff. DON B indicated staffing was rough and indicated understanding with the staffing concerns at the facility. The facility failed to ensure sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility did not ensure that 3 (R11, R10, and R12) of 5 residents reviewed for receiving a psychotropic medication were free from unnecessary drugs. R11 receives Quetiapine, an antipsychotic medication, for agitation/anxiety. R10 receives Citalopram (antidepressant) and was receiving Haldol (antipsychotic) and the physician orders do not indicate which diagnoses are associated with these medications. R12 receives Quetiapine, an antipsychotic medication, for dementing illness with behaviors. This is evidenced by: The facility policy titled, Medication Monitoring and Management, with an effective date of May 2018, indicates, in part: .Procedures: A.5) When a resident receives a new medication, the medication order is evaluated for the following: .b. A written diagnosis, an indication, and/or documented objective findings support each medication Example 1 R11 was admitted to the facility on [DATE] with diagnoses including breast cancer, multiple sclerosis, bipolar disorder, hyperlipidemia, kidney disease, and unspecified fall. R11's current physician order states, in part; .Quetiapine Fumarate tab 50 mg give 3 tablets by mouth at bedtime for agitation/anxiety. Start date 8/23/24 . It is important to note agitation/anxiety is not an appropriate indication of use for an antipsychotic. On 10/9/24 at 11:30 AM, DON B (Director of Nursing) indicated that R11 did not have an appropriate diagnoses or indication for the use of their antipsychotic, Quetiapine. The facility failed to ensure residents receiving antipsychotic medications have appropriate diagnoses for medication use. 39849 Example 2 R10 admitted to the facility on [DATE] with diagnoses that include, in part: Alzheimer's disease, Bipolar disorder, and dementia. R10's September 2024 Physician Orders, include, in part: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Citalopram Hydrobromide Oral Tablet 10mg - Give 1 tablet by mouth one time a day for ****NURSE TO ENTER DIAGNOSIS****. Start date: 8/29/24 2) Haloperidol Lactate Oral Concentrate 2mg/ml - Give 0.5ml by mouth every 2 hours as needed for ****NURSE TO ENTER DIAGNOSIS****. Start date: 8/28/24. Discontinue Date: 9/11/24. Surveyor reviewed R10's medical record for medication consents that would indicate the associated diagnoses. No consents were found. Surveyor requested these from the facility. On 10/8/24 at 2:35 PM, Surveyor interviewed DON B (Director of Nursing). During the interview DON B indicated that the facility did not have the signed written consents for the medications for R10. On 10/9/24 at 4:09 PM, Surveyor interviewed DON B (Director of Nursing) who indicated that R10's psychotropic medications should have a diagnoses associated with the physician orders for them. DON B indicated that a lot of times the physician order gets put in and then the diagnoses get added later, usually within 48 hours. DON B indicated that without the diagnoses included in the physician order you would not know what diagnoses each medication is being given for. DON B indicated that he should have gone back into the chart and added them. Example 3 R12 admitted to the facility on [DATE] with diagnoses that include, in part: unspecified dementia and altered mental status. R12's Current Physician's Orders, include, in part: 1) Quetiapine Fumarate Tablet 25mg -- Give 1 tablet by mouth at bedtime for Dementing illness with associated behavioral symptoms. Start date 9/12/24. It is important to note that dementing illness with associated behaviors is not an appropriate indication of use for an antipsychotic. On 10/9/24 at 1:25 PM, Surveyor interviewed DON B. DON B indicated that R12 did not have an appropriate diagnosis or indication for the use of their antipsychotic, Quetiapine.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on interview and record review, the facility did not ensure residents are free of significant medication errors for 3 of 7 total sampled residents (R1, R9, and R13). R9 did not receive a dose of her Apixaban (blood thinner) on 9/7/24 at 8:00 PM. R13 did not receive 2 doses of her Insulin Glargine (Long-Acting Insulin) on 9/20/24 and 9/22/24 at 8:00 PM. R1 did not receive scheduled doses of insulin and had an anticoagulant held and not given without a valid signed physician's order, nor was the doctor notified of these medication errors. Example 1 R9 admitted to the facility on [DATE] with diagnoses that include, in part: Nontraumatic subarachnoid hemorrhage from unspecified intracranial artery, Acute embolism and thrombosis of inferior vena cava, dysphagia (difficulty swallowing) . R9's September 2024 Medication Administration Record (MAR) indicates, in part: Apixaban Oral Tablet 2. 5mg - Give 2 tablet via G-Tube two times a day for antiplatelet. Start date: 9/7/24. R9's 9/7/24 8:00 PM dose has documented 16, which the MAR chart code indicates means Med Unavailable - Pharmacy Contacted. On 10/9/24 at 11:35 AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated that if a med is marked as not available and is not given it is considered a medication error. Surveyor reviewed R9's MAR with DON B who indicated he was not aware of a pharmacy issue and that it is correct that 16 means the medication was unavailable. DON B indicated the medication was not given and should have been and that the physician should have been contacted. Example 2 R13 was admitted to the facility on [DATE] with diagnoses that include in part: Type I Diabetes Mellitus (In this type of diabetes, the pancreas can't make insulin or makes so little of it that you need to take insulin to live) and Gastroparesis. R13's September 2024 MAR indicates, in part: Insulin Glargine Solution 100unit/ml - Inject 16 unit subcutaneously (beneath the skin) two times a day for diabetes. Start Date 9/17/24. R13's 9/20/24 and 9/22/24 08:00PM doses have documented 9, which the MAR chart code indicates means Other/See Progress Note. R13's Electronic Medication Administration Record (eMAR) progress note for 9/20/24 do not contain a note referencing Insulin Glargine. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's eMAR progress note for 9/22/24 at 9:14PM indicates: Note Text: Insulin Glargine .held did not eat. On 10/8/24, Surveyor interviewed LPN F (Licensed Practical Nurse) and during the interview reviewed R13's MAR, which included blood sugar readings, and physician orders for September. LPN F indicated she could not find parameters for when to hold R13's Insulin in the orders and there should be. LPN F indicated she would contact the on call for recommendations prior to making a decision to hold insulin. On 10/8/24 at 11:35 Surveyor interviewed DON B (Director of Nursing) and reviewed R13's 9/20/24 and 9/22/24 Insulin Glargine doses that were held and the overall physician orders. DON B indicated he was unable to find any hold orders for R13's insulin. DON B indicated for the held doses on 9/20/24 and 9/22/24 he would have expected the nurse to contact the doctor for guidance instead of just holding the dose. 50285 Example 3 R1 admitted to the facility on [DATE] with diagnoses that include, in part: chronic respiratory failure, chronic obstructive pulmonary disease, Type 2 Diabetes Mellitus without complications, hypertensive heart disease with heart failure, chronic congestive heart failure, personal history of pulmonary embolism, personal history of other venous thrombosis and embolism. R1's Minimum Data Set (MDS) dated [DATE] indicates that R1 has a Brief Interview of Mental Status (BIMS) of 14, indicating R1 is cognitively intact. R1's physician orders dated 8/8/24, state in part: insulin glargine subcutaneous solution 100 unit/mL (Insulin Glargine). Inject 10 units subcutaneous at bedtime related to Type 2 Diabetes Mellitus without complications. R1's hospital transfer orders from (Hospital Name) dated 8/7/24 indicate in part: start taking Enoxaparin Sodium Injection Solution 300 mg/3 mL (Enoxaparin Sodium). Inject 1.5 mL subcutaneously every morning and at bedtime for Blood clot prevention for 5 days. Start Date 8/9/24. End date: 8/14/24. R1's Medication Administration Record (MAR) for August 2024 shows: Insulin Glargine for 8/16/24 and 8/17/24 indicates H for evening dose Held - Medication not administered. On 8/22/24 evening dose for Insulin Glargine was blank - Medication not administered. The 6:00 AM doses for Enoxaparin Sodium Injection for dates 8/10/24, 8/11/24, 8/13/24, and 8/14/24 as well as the 7:00 PM doses for dates 8/9/24, 8/10/24, 8/11/24, 8/12/24, and 8/13/24 indicate H - Medication not administered. On 9/19/24 and 9/26/24 Insulin Glargine 7:00 PM dose indicates blank - Medication not administered. Important to note: R1's medical record did not include a signed hold order from the physician for Enoxaparin. (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	10/17/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's hospital discharge notes date 9/3/24 indicate the following, in part: . a possible concern over his prior DVT/PE (deep vein thrombosis/pulmonary embolism) and ongoing warfarin dose . his INR (International Normalized Ration, which is a blood test that measures how long it takes for blood to clot) is only 1.5, suggesting that he is subtherapeutic and at increased risk of a clot . we will bridge with Lovenox/Enoxaparin 1 mg/kg BID (two times a day) . Medication at time of discharge: Enoxaparin (Lovenox) 150 mg/mL subcutaneous syringe. Inject 1 ML under the skin 2 times per day for deep vein thrombosis. R1's eMAR for September 2024 includes in part: Enoxaparin Sodium Injection Solution filled syringe 150 mg/mL (Enoxaparin Sodium). Inject 1 mL subcutaneously two times a day for DVT prevention. Start date 9/4/24. discharge date [DATE]. Important to note: R1's medical record did not include a signed discharge order from the physician for Enoxaparin. On 10/8/24 at 1:27 PM, Surveyor interviewed DON B (Director of Nursing) who stated that any of the nurses can transcribe physician orders. DON B indicated that he goes in and confirms verbal orders himself. DON B denied keeping any hard charts or written signed physician orders. Surveyor asked DON B what a blank on the eMAR meant. DON B indicated that blanks meant there was a missed dose. On 10/8/24 at 2:32 PM, Surveyor interviewed DON B who stated he assumed that all physician orders were signed electronically. Surveyor reviewed the medication history in R1's medical record, which indicated that no medications had been signed since 6/19/24. Surveyor asked DON B if he would consider medications that were ordered by the physician and not administered a medication error. DON B stated yes, he would consider that a medication error. Surveyor asked DON B if the physician should be contacted for missed medications/med errors. DON B stated yes, the physician should have been contacted.

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	10/17/2024

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility did not conduct and document an up-to-date facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility did not review and update that assessment, as necessary, and at least annually. The lack of assessment has the potential to affect all 38 residents. The facility's Facility Assessment has not been updated annually and/or as necessary. Facility assessment dated ,d+[DATE], does not address current resident population at facility and resources/education needed for facility to appropriately care for resident population. Evidenced by: The facility document, Facility Wide Resource Assessment, dated 12/22, states in part; .The facility wide resource assessment is required by the nursing home requirements of participation to identify and analyze the facility's resident population and identify the personnel, physical plant, environmental and emergency response resources needed to competently care for the residents during day-to-day operations and emergencies. On 10/7/24, Surveyor asked for most up-to-date Facility Assessment. NHA A (Nursing Home Administrator) provided Surveyor a power point titled, CMS minimum staffing mandate and facility assessment enhancements. Surveyor asked NHA A if facility had any sort of actual assessment. On 10/8/24 at 7:50 AM, Surveyor asked CNC E (Clinical Nurse Consultant) about power point and if facility had anything else to provide. CNC E stated, Yes, that's embarrassing. CNC E indicated they would look and see if there was any sort of assessment completed. On 10/8/24 at 8:00 AM, NHA A indicated NHA A will continue looking for Facility Assessment. NHA A indicated NHA A is new to facility and position. NHA A indicated the power point is not an actual facility assessment of the population that is served at facility. On 10/9/24 at 1:00 PM, NHA A provided Facility Wide Resource Assessment, dated 12/22, to Surveyor. NHA A indicated NHA A will be completing an accurate and up-to-date facility assessment. NHA A indicated assessment is not accurate and assessment should be updated annually and as needed. The facility failed to conduct and document an up-to-date facility wide assessment to determine what resources are necessary to care for its resident population.