STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525330	A. Building B. Wing	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middleton Village Nursing and Rehab	6201 Elmwood Ave Middleton, WI 53562

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on interview and record review, the facility did not ensure 1 of 4 residents (R6) reviewed was able to choose their physician. R6 had elected not to have the facility's Medical Director be his Primary Care Physician (PCP). The facility's Medical Director signed R6 out Against Medical Advice (AMA) when R6 chose to see his own PCP and the PCP wrote discharge orders. Evidenced by: The facility's policy titled Resident Rights revised August 2009, states in part: .Employees shall treat all residents with kindness, respect, and dignity .c. Choose a physician and treatment and participate in decisions and care planning; .2. Residents are entitled to exercise their rights and privileges to the fullest extent possible.3. Our facility will make every effort to assist each resident in exercising his/ her rights to assure that the resident is always treated with respect, kindness, and dignity . R6 was admitted to the facility on [DATE] with diagnoses that include: status post (s/p) coronary artery bypass graft x 3, congestive heart failure, type 2 diabetes mellitus, muscle weakness, anxiety disorder, and major depressive disorder. R6's most recent Minimum Data Set (MDS) dated [DATE] states that R6 had a Brief Interview of Mental Status (BIMS) of 14/15, indicating that R6 is cognitively intact. R6's Admission Agreement states in part, .P. Choice of Physician and Physician Policy Notification: The facility wants you to feel comfortable with your medical care. To this end, each resident has the right and obligation under the law to select their own physician for the time he or she is a resident of this facility .At any time, the resident has the right to assign or replace a physician .This facility has obtained a medical director to act as a liaison with the physicians serving the facility's residents and to assist the facility on addressing any issue related to medical care . It is important to note that the facility's medical director's name and phone number is written in the space provided, but R6 did not initial the spot indicating that he had selected the facility's medical director as his PCP. On 11/14/22, R6's wife had taken him to see his PCP. (continued on next page)

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

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW C's (Social Worker) note dated 11/14/22 states in part, Writer received a voicemail from resident's wife Sunday 11/13/22 in late evening stating that the resident was very anxious to discharge home. Resident's wife stated in the voicemail that the resident has a scheduled appointment early this morning and that she was going to discuss discharging the resident home with the doctor he was scheduled to see .This writer went to speak with the resident's wife regarding discharge planning to see if she would agree to wait until discharge orders are given from our NP (Nurse Practitioner) and until I could verify that the resident would receive care post discharge from HH (Home Health). This writer provided education that the facility must plan a safe d/c (discharge) and at this time, resident did not have a safe d/c plan in place .The resident's wife stated that she will not be bringing the resident back under any circumstances because the doctor that they saw during today's appointment said that there is no reason the resident cannot discharge and claims to have HH services set up to start in a week. This writer began to explain that since the resident does not yet have discharge orders from our facility NP or MD (Medical Doctor), then if he does[sic] return it would be considered discharging AMA .Resident's wife began raising her voice and saying that he was not leaving AMA because the doctor through [clinic] gave him discharge orders. This writer again explained to her that providers outside of our facility have no jurisdiction to write discharge orders and that because our facility NP or MD have not yet written discharge orders and because HH has not been verified, it would be considered AMA if he does not return . On 6/7/23 at 9:59 AM, Surveyor interviewed SW C. Surveyor asked SW C what the process was for discharge planning, SW C stated that they have a care conference upon admission, when we decide on a date for discharge, we update the MD/ NP for orders, send orders to the pharmacy, and make referral to HH if appropriate. Surveyor asked SW C if residents are allowed to choose their own PCP, SW C stated that they have a Medical Director that sees the whole building, but they are allowed to see their own PCP. Surveyor asked SW C if a resident's PCP is allowed to write discharge orders, SW C stated that they are, but she also confers with therapy and nursing to see if they are comfortable with the discharge. Surveyor asked SW C what the financial repercussions are if a resident discharges AMA, SW C stated that she believes that Medicare will bill them for their entire stay. Surveyor asked SW C if a resident's PCP wrote discharge orders, would it still be considered leaving AMA, SW C stated if we weren't told he wasn't staying. On 6/7/23 at 10:43 AM, Surveyor spoke with FM D (Family Member). Surveyor asked FM D about R6's doctor's appointment and discharge, FM D stated that she took R6 to see his PCP who reported that R6 could discharge and that he would take over his medications and send HH to their house. FM D stated that she returned to the facility to pick up R6's belongings and that SW C screamed at her all the way down the hallway saying that the only person that could dismiss R6 was their doctor and that she would stop Medicare payments if she didn't bring R6 back to the facility. On 6/7/23 at 3:35 PM, Surveyor interviewed SW C. Surveyor reviewed R6's Admission Agreement with SW C. Surveyor asked SW C if it appeared that R6 consented to have the facility's Medical Director to be his PCP, SW C stated no. Surveyor asked SW C who was responsible to follow up with the resident regarding his PCP preference, SW C stated that admissions should have followed up and that she was not aware that R6 had not elected the Medical Director to be his PCP and that he was seeing his own PCP. Surveyor asked SW C if R6's PCP wrote orders for his discharge, would he still be considered leaving AMA, SW C stated no. Surveyor asked SW C when she told R6's wife that their PCP does not have jurisdiction, was that a true statement, SW C stated no. (continued on next page)

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/23 at 5:22 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if residents can choose their own PCP, DON B stated absolutely. Surveyor asked DON B who is responsible for following up with resident's when they elect not to have the Medical Director as their PCP, DON B stated that the admissions department should have followed up, but that R6 allowed the facility's NP and MD to see him, and he could have refused those visits.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on interview and record review, the facility did not promptly consult with the physician for 3 of 24 (R2, R6, and R7) sampled residents when they experienced significant changes in condition or met parameters set by the physician to be notified. R2 has a significant cardiac history with previous myocardial infarction. The facility failed to promptly consult with R2's physician when R2 presented with chest pain and numbness in the arm and face and a noted respiratory rate of 32 on [DATE]. R2 was later sent to the hospital and found to have an acute myocardial infarction (MI). The facility's failure to immediately consult with R2's physician when she was experiencing chest pain and numbness in the arm and face created a finding of Immediate Jeopardy (IJ) beginning on [DATE]. DON B (Director of Nursing) was informed of the IJ on [DATE] at 3:46 PM. The IJ was removed and corrected on [DATE]. Evidenced by: INTERACT: Change of Condition: Signs and Symptoms: Chest pain, pressure, or tightness. Immediate (Notify the attending or on-call MD, NP, or PA on call as soon as possible). New or abrupt onset, unrelieved by current medications, OR accompanied by diaphoresis, change in vital signs or new EKG changes. Note: Hospital record dated [DATE] indicates that R2 presented with shortness of breath that has been chronic (~4 years) since her shoulder surgery. R2 presented with chest pain that was located on her left side and radiated down her left arm. She felt lightheaded. She also notes having had palpitations during this episode. INTERACT: Change of Condition: Vital Signs: Respiratory Rate. Immediate. Respirations > 28, < 10/minute. Note: Facility Health Status Note, dated [DATE] at 3:16 AM indicates R2 had a respiratory rate of 32. According to cdc.gov, A heart attack, also called a myocardial infarction, happens when a part of the heart muscle doesn't get enough blood. The more time that passes without treatment to restore blood flow, the greater the damage to the heart muscle. The Facility policy titled, Notification of Changes Guideline, states in part . Purpose: It is the practice of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). All pertinent information will be made available to the provider by the facility staff. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident. OVERVIEW OF COMPONENTS OF THE GUIDELINE 1. Requirements for notification of resident, the resident representative, and their physician: 2) A significant change in the resident's physical, mental and psychosocial status. (i) A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. 3) A need to alter treatment significantly. (i) A significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. R2 was admitted to the facility on [DATE]. R2 has diagnoses that include: cerebral infarction, hemiplegia, acute embolism and thrombosis, Type 2 diabetes mellitus, major depressive disorder, essential hypertension, atherosclerotic heart disease, heart failure, and chronic obstructive pulmonary disease (COPD). R2 is [AGE] years old. R2 is a full code (indicating R2 would like CPR (cardiopulmonary resuscitation) performed in the event her heart would stop). R2's most recent Minimum Data Set (MDS), dated [DATE], indicates R2 is supervision of one staff member for bed mobility, dressing, hygiene, and toileting. R2 requires limited assistance of one staff member for transfers. R2 has a Brief Interview of Mental Status (BIMS) of 12 indicating moderate cognitive impairment. On [DATE] at 3:16 AM, Health Status Note states, Resident woke up in a state of panic stating she was having chest pain and that her heart was going to stop, that she couldn't feel her arms, they were going numb and that her mouth was also going numb. Assessed resident, her BP (blood pressure) was ,d+[DATE], pulse 69, R (respirations) 32, T (temperature) 98.3, and pulse ox (oxygen) 100% on room air. Heart rhythm strong and regular with an apical pulse of 70. She states her chest hurts when I pushed on it lightly. She kept repeating and crying stating, I don't want to die! I don't want to die! Spoke with her about anxiety, she states she used to take something but that she didn't know what it is and should be 'in my charts.' Will pass along in report to see if we can get something ordered for anxiety for this resident. Note: RN J (Registered Nurse) did not promptly update the provider on R2's change of condition which included presenting with chest pain, numbness, and elevated respiratory rate in a resident with known cardiac history. On [DATE] at 4:00 AM, electronic medication administration record (eMAR) - Medication Administration Note states, Hydrocodone-Acetaminophen ,d+[DATE] MG (milligram), give 1 tablet by mouth every 4 hours as needed for pain. Pain in her chest/muscle/skeletal. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:00 AM, eMAR - Medication Administration Note states, Hydrocodone-Acetaminophen , d+[DATE] MG (milligram), give 1 tablet by mouth every 4 hours as needed (PRN)for pain. Follow-up Pain Scale was: 7. PRN (as needed) Administration was: Effective, somewhat effective according to resident. (Of note, resident continues to have pain of 7 1 hour after pain medication given). On [DATE] at 6:51 AM, eMAR - Medication Administration Note states, Acetaminophen Tablet 650 MG, give 1 tablet by mouth every 8 hours as needed for Pain. Do not exceed 4000mg APAP (Acetaminophen)/24 hrs. (hours). Requested, crying. (Note, resident was given pain medication and continued crying despite receiving pain medication 3 hours earlier. It should be noted the MD was still not consulted despite continued pain and crying). On [DATE] at 11:02 AM, eMAR - Medication Administration Note states, Acetaminophen Tablet 650 MG, give 1 tablet by mouth every 8 hours as needed for Pain. Do not exceed 4000mg APAP (Acetaminophen)/24 hrs. (hours). PRN Administration was: Ineffective. Follow-up Pain Scale was: 10. On [DATE] at 13:06 (1:06 PM), Health Status Note states, Received report that resident began to experience discomfort in chest around 01:00 (1:00 AM) and that resident had received PRN Hydrocodone-Acetaminophen Tablet ,d+[DATE] MG at 04:00 (4:00 AM). NOC (night) RN (registered nurse) reporting attributing discomfort to resident history of feeling anxious. Suggested writer speak with NP (Nurse Practitioner) about PRN anxiety prescription. NOC RN reported VSS (vital signs stable). Writer went to assess resident and confirmed VSS. Encouraged resident to take deep breaths and resident reported lessening of discomfort a little. Resident asking for pain medication that writer administered acetaminophen 650 mg at 06:51 (6:51 AM). Ineffective. Spoke to NP when arrived at 09:20 (9:20 AM) and was asked to give resident Tums (administered at 09:37 (9:37 AM)). NP visited with resident and asked writer to call 911 and transfer to ER (emergency room). Resident transferred at 09:50 (9:50 AM). Note: The oncoming shift Nurse did not update the physician or NP of R2's change of condition until the NP was in the building approximately 8 hours later. Note: The oncoming Nurse notes state the nurse completed an assessment and vitals signs on R2, but there is no documentation in R2's medical record to indicate this was completed. Hospital notes include in part . Hospital Encounter: H&P (History and Physical) dated [DATE] states in part . Recent admission [DATE] for partially occlusive thrombus at the left carotid terminus (blood clot in the artery) as well as chronic right ICA (internal carotid artery) occlusion who presents with chest pain, found to have anterior STEMI (ST elevated myocardial infarction/heart attack). On presentation to the cardiology team, she endorses that she began having symptoms last night (chest pain). She noted shortness of breath that has been chronic (4 years) since her shoulder injury. She notes that the chest pain was located on her left side and radiated down her left arm. She denies and LOS (loss of sensation). She felt lightheaded. She also notes having had palpitations during this episode. Ejection Fraction: 65% on [DATE]. Ejection Fraction: [DATE], left ventricular ejection fraction, by visual estimation is, 35%. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ECG (Echocardiogram) [DATE], post Cath (catheterization) Anterior infarct (cited on or before 03-FEB (February)-2023 ECG [DATE], per Cath (catheterization) Anteroseptal infarct, possibly acute Lateral injury pattern ** ** ACUTE MI/STEMI ** ** Assessment and Plan: She is presenting following a STEMI s/p (status post) stenting to LAD (left anterior descending) #Anterior STEMI ,d+[DATE] (secondary to) possible embolus -TTE (transesophageal echo) to evaluate heart function post MI (myocardial infarction) Disposition: Patient with STEMI in need of medical optimization. Cardiovascular Medicine Attending Addendum: In addition, I note the following: R2 was admitted after an anterior STEMI s/p what appeared angiographically more like embolic occlusion of the mLAD (mid left anterior descending) (minimal underlying CAD (coronary artery disease) by IVUS (intravascular ultrasound)). Patient has had systemic symptoms (night sweats, chills, weight loss) and does have elevated inflammatory markers. Hospital Encounter: PT (Physical Therapy), from [DATE], states in part . Medical Diagnosis: STEMI involving left anterior descending coronary artery. Medical Diagnosis: STEMI involving left anterior descending coronary artery Patient Active Problem List: Stroke, acute, embolic Acute on chronic CHF Aortic valve stenosis STEMI involving left anterior descending coronary artery (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident was admitted to [hospital name] on ,d+[DATE] with chest pain, found to have anterior STEMI. She underwent cardiac Cath (catheterization) with PCI (percutaneous intervention into coronary artery) and DES (drug eluding stent) to LAD (anterior descending), IVUS (intervascular US), and aspiration of thrombectomy of LAD on ,d+[DATE]. On ,d+[DATE], she had a stroke, code called due to blurred vision and left sided weakness. CT (CAT Scan/x-ray) revealed no hemorrhage, early ischemic change, large vessel occlusion or perfusion deficit. It does show hypoattenuation in the left lentiform nucleus into the left caudate and appearance is suggestive of chronic vs subacute injury. Hospital Encounter: Discharge Summary, from [DATE] states in part . Inpatient Discharge Summary: Briefly, R2 was admitted to [Hospital Name] for STEMI s/p stenting to LAD. She was also found to have severe aortic stenosis on TTE (transesophageal echo) with reduced LVED (left ventricular ejection fraction) 35%. She suffered a PEA (pulseless electrical activity) arrest on [DATE] and passed away at 16:03 (4:03 PM). Hospital Course: #Anterior STEMI #Concern for Hypercoagulable state She was found to have 100% occlusion on mid LAD. DES (drug eluding stent) x1 placed in the mid LAD. IVUS (intervascular US) of LAD showed findings consistent with embolic. TEE ,d+[DATE] with valvular etiology for her embolic lesion and atrial thrombus. Given her history of DVT (deep vein thrombosis/ blood clot) and stroke, hematology was consulted and started hypercoagulable work up, with results pending at the time of PEA arrest. She was started on DAPT (aspirin, Plavix) and apixaban. Patient developed another episode of chest pain in the early AM of ,d+[DATE], with ECG showing ongoing ST elevation in the anterior leads. She was brought emergently to the Cath lab, with LHC (left heart catheterization) showing patent LAD stent and new obstructive disease. #Aortic Stenosis TTE ,d+[DATE] demonstrated severe aortic stenosis in low output state. Interventional Cardiology and Cardiac surgery were consulted for TAVR/SAVR (Transaortic valve replacement/surgical aortic valve replacement-heart valve replacement) work up. #Concern for TIA History of L MCA stroke Patient demonstrated weakness and left sided sensory changes on ,d+[DATE] so a stroke code was called. Symptoms resolved. #PEA Arrest (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Patient developed sudden onset dyspnea (shortness of breath) and diaphoresis (sweating) in the afternoon of ,d+[DATE] after getting out of bed for a bowel movement. Code Blue was called. She was found to be in PEA (pulseless electrical arrest/no heartbeat) arrest CPR was performed for 30 minutes. Patient pronounced dead at 16:03 (4:03 PM). On [DATE] at 2:49 PM, Surveyor interviewed NP I (Nurse Practitioner). Surveyor asked NP I about R2's hospitalization and her expectations for notification. NP I stated, I would have expected a provider to be notified, especially in this situation. From what I remember, the resident complained of chest pain in the middle of the night. When I got to the facility, staff began to tell me about it. I went down to R2's room and I found her hysterical, complaining of pain and numbness. I felt she needed to be evaluated in the ER. R2 had a MI and was in the ICU (intensive care unit) and passed away on [DATE]. I don't know the specifics of the cause of death. Even with vital signs stable, I would have expected the on-call physician to be notified of this change of condition. On [DATE] at 3:33 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B about R2's hospitalization and expectations for change of condition for a resident. DON B stated, Any review or documentation for that resident I can say I don't remember but I will look. Absolute notification. I would not expect staff to continue to monitor the resident. I would expect she be sent out. Surveyor requested a copy of any education or auditing done related to the change of condition for R2. Note: Surveyor did not receive any documentation of education. On [DATE] at 4:43 PM, Surveyor interviewed LPN N (Licensed Practical Nurse). Surveyor asked LPN N what the facility used for a standard of practice of change of condition (COC). LPN N stated, We use Interact for change of condition. Surveyor asked LPN N if she could find the eInteract that was completed for R2's change of condition on [DATE]. LPN N stated, There was no eInteract completed in the computer. The eInteract should be completed each time there is a COC. On [DATE] at 8:22 AM, Surveyor interviewed NP I. Surveyor asked NP I about R2's change in EF (ejection fraction) from October to February and if delay and STEMI could have caused this to occur. NP I stated, It is definitely possible that it could have contributed to that. An MI could cause decreased EF as the heart muscle is dying. It is pretty safe to assume the [DATE] MI contributed to the decrease in EF. On [DATE] at 11:55 AM, Surveyor spoke with DON B. During this phone call DON B indicated that she had information that she was going to be sending to Surveyor. DON B also stated, I educated the Nurse who was caring for R2 the same day and I also completed audits of staff. All staff knew what to do for a change of condition, so I did not complete any education. On [DATE] at 12:21 PM, Surveyor received an email from DON B including what appears to be a handwritten note out of a notebook that states, RN J interview for R2 incident on 2.3.23. LM (left message) 2.3, 12:38 ([DATE] at 12:38 PM). Vitals/listened to HR (heart rate). Appeared muscular skeletal, fine when we weren't in room. Education given on COC (change of condition). Note in facility electronic charting system verifies s/s (signs and symptoms) that should have been reported. RN J v/u [sic] statement above. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Attached is a copy of a handwritten audit indicating it was completed on [DATE] with 10 Nurses names. Handwritten answers to question, If a resident presented with chest pain, what would you do? Column indicating if they passed or failed. Form indicates all staff involved in the audit passed. There is no indication of education provided. The last item included in the email was a typed note stating, This writer asked RN J to give description of the R2 condition on [DATE]. RN J stated that the resident complain [sic] of chest pain, and was very anxious, but resident has anxiety episodes before. RN J stated that when staff left the room her anxiety was less, and resident was calm with no complaints. RN J stated that she checked her vitals and listened to HR (heart rate), and all was WNL (within normal limits), and RN J noted no irregularities. RN J felt that it was muscular skeletal. As she said she lightly pushed on the area and residents stated that she could feel pain. Education provided to RN J on COC. This writer educated that per RN J's note in electronic charting system it verified that signs and symptoms should have been reported. Education provided to RN J regarding Chest pain and to ALWAYS update NP or MD (medical doctor) regarding chest pain. RN J verbalized understanding and stated, I feel so bad, I just thought she was having anxiety as she had in the past. This writer again stated that even if she thought it was anxiety, it is always best and safest practice to update NP for any COC and follow their orders/guidance. Nurses are not able to diagnose. RN J stated, No, I know that I should have called. (Note: There is no signature on this document to indicate what time interview and education was conducted or who wrote the note. The document also is not signed by RN J that she acknowledged and agreed with what was written.) The facility's failure to notify the physician timely with an acute change of condition resulted in a finding of immediate jeopardy which was removed on [DATE], when the facility implemented the following action plan: Immediate Corrective Action for R2 (affected resident) Beginning on [DATE] DON B provided education to nursing staff on recognition of change of condition and the need to notify the physician immediately with change of condition including chest pain. On [DATE] DON B provided education to the nursing staff on the facility's policy regarding notification of the physician. On [DATE] DON B audited nursing staff regarding chest pain. Nurses were able to verbalize the following: 1. Identifying chest pain as a possible cardiac event. 2. Immediately notify physician 3.Follow MD/NP orders 4. If unable to contact MD/NP, to send resident out for emergent evaluation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Audits on change of condition continued through quality assurance process. 42038 R6 experienced a 16-pound weight loss and the facility failed to update the physician. R7 experienced a 16-pound weight gain and the facility failed to update the physician. These are a level 2 example no actual harm. Example 2 The facility's policy titled Weight Monitoring Guideline revised [DATE], states in part: .Residents will be weighed; documentation will be recorded in PCC (Point Click Care): *Upon admission and re-admission .* Daily for three days .* As prescribed by the physician or mid-level practitioner .The Licensed Nurse: *Will verify the accuracy of the weight by comparing the weight with the mist recently recorded weight. *Direct a re-weight for variances < or > 5 pounds. *Consult the physician and dietian [sic]/ designee with a confirmed 5% weight variances in 30 days and 10% in 6 months and/ or as ordered by the physician with weight parameters. *For residents on daily weights for fluid volume overload prevention and monitoring weight notification parameters should be discussed with the physician and at minimum consultation should be completed with a 5-pound weight change in 1 week for residents with heart failure or fluid volume overload . R6 was admitted to the facility on [DATE] with diagnoses that include s/p (status post) coronary artery bypass graft x 3, congestive heart failure, type 2 diabetes mellitus, muscle weakness, anxiety disorder, and major depressive disorder. R6's most recent Minimum Data Set (MDS) dated [DATE] states that R6 had a Brief Interview of Mental Status (BIMS) of ,d+[DATE], indicating that R6 is cognitively intact. R6's hospital discharge orders dated [DATE] stated: Daily weights, call if gain 3# in one day or 3# in one week. Fluid Restriction- 2000 cc (cubic centimeters)/ per day. The facility's physician orders dated [DATE] state: Daily weights every day shift Notify DM (Dietary Manager) if weight increases by 3 pounds in one day or 3 pounds in 1 week. Fluid Restriction- 2000 cc (cubic centimeters)/ per day. R6's weights are as follows: ,d+[DATE]: 214.2 lbs. (pounds) ,d+[DATE]: no weight obtained (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	,d+[DATE]: no weight obtained ,d+[DATE]: no weight obtained ,d+[DATE]: 215 lbs. ,d+[DATE]: 206.4 lbs. ,d+[DATE]: 206.8 lbs. ,d+[DATE]: 202.7 lbs. ,d+[DATE]: no weight obtained ,d+[DATE]: 202.6 lbs. ,d+[DATE]: 202.6 lbs. ,d+[DATE]: 204.4 lbs. ,d+[DATE]: 203 lbs. ,d+[DATE]: no weight obtained ,d+[DATE]: 202.1 lbs. ,d+[DATE]: 203.6 lbs. ,d+[DATE]: 205.1 lbs. ,d+[DATE]: 198 lbs. ,d+[DATE]: 198.6 lbs. ,d+[DATE]: 197.8 lbs. ,d+[DATE]: 198.2 lbs. It is important to note that there is no documentation that the facility notified the physician that weights were not obtained on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. Example 3 R7 was admitted to the facility on [DATE] with diagnoses that include: right above the knee amputation, sepsis, type 2 diabetes mellitus, toxic encephalopathy, and malignant neoplasm of the bladder. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7's most recent Minimum Data Set (MDS) dated [DATE] states that R7 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating that R7 is cognitively intact. R7's MDS also indicates that he required extensive assistance of 2 people for bed mobility and transfers. R7's physician orders dated [DATE] state: Weights every day shift for 3 days. Weights every day shift every 7 days for 3 weeks. Weights every day shift starting on the 1st and ending on the 7th every month. R7's weights are as follows: ,d+[DATE]: no weight obtained ,d+[DATE]: 138.5 lbs. ,d+[DATE]: no weight obtained ,d+[DATE]: 136.6 lbs. ,d+[DATE]: 142.4 lbs. ,d+[DATE]: 153 lbs. ,d+[DATE]: 145.2 lbs. It is important to note that there is no documentation indicating that the facility updated the physician when the weights were not obtained. Additionally, there is no documentation indicating that the facility updated the physician when R7 gained 14.5 lbs. from ,d+[DATE] to ,d+[DATE], as well as when he lost 7.8 lbs. from , d+[DATE] to ,d+[DATE]. No re-weights were documented. On [DATE] at 5:22 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she would expect facility staff to obtain re-weights if there is a discrepancy with a resident's weight, DON B stated yes, Surveyor asked DON B if she would expect that nursing staff updated the physician when there is a significant weight loss or gain, DON B stated yes.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not follow their grievance process for 1 of 13 Residents (R5). R5's dentures were reported missing. The facility did not follow their grievance process for missing items and did not reach a resolution with R5 regarding her missing dentures. This is evidenced by Facility policy, entitled Grievance Guidelines, dated 11/28/2017, includes in part: The object of the grievance guideline is to ensure the facility makes prompt efforts to resolve grievances a resident may have. the intent of the grievance process is to support each residence right to voice grievances such as those about treatment, care, management of funds, lost clothing, or violation of rights . and to assure that after receiving a complaint or grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution. a grievance or concern can be expressed orally to the grievance official or facility staff or in writing using a grievance form . may be given to any staff member who will forward the grievance to the grievance office . any employee of this facility who receives a grievance shell immediately attempt to resolve the complaint within their role and authority . upon receipt of a grievance or concern . the grievance official will initiate the appropriate notification and investigation processes . the grievance official will complete a response to the resident or resident representative which includes: date of grievance or concern, summary of grievance, investigation steps, findings, resolution outcome and actions taken and date decision was issued . R5 admitted to the facility on [DATE]. She had upper and lower dentures upon admission. R5's MDS (Minimum Data Set), with ARD (Assessment Reference Date) of 9/12/22, indicates R5's cognition is moderately impaired with a BIMS (Brief Interview for Mental Status) score of 9 out of 15. R5's Nurse Notes, dated 9/10/22, include Resident's upper denture is missing. The writer and CNA (Certified Nursing Assistant) this morning noticed resident was not wearing her upper denture . Not seeing it in the room . we thought maybe R5's husband who visits daily had taken it home for cleaning. Resident has poor memory and is unable to help. Husband denies taking home upper denture and remembers she had it night of 9/9/22. A thorough check of room and bed did not reveal the denture. Kitchen staff also denied finding a denture today or yesterday. We will interview laundry staff Sunday/Monday. Meanwhile she will need a soft diet. R5's Nurse Notes, dated 9/11/22, include Resident ate less than 25% or refused meals for 24/hr. Client needs soft foods as she has lost her dentures. At breakfast today she ate her fill of oatmeal and applesauce On 6/6/23 at 3:28 PM DON B (Director of Nursing) indicated it is not the responsibility of the facility to replace dentures. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/23 at 4:45 PM SSD C (Social Services Director) indicated R5 could have wrapped her dentures up in a napkin and left them on her meal tray or threw them in the garbage. On 6/7/23 at 10:00 AM SSD C indicated she investigated the missing dentures and discussed it with NHA A (Nursing Home Administrator), but they never found the dentures and NHA A indicated it was the fault of R5 for tossing her dentures away. R5 discharged on [DATE]. SSD C indicated she did not fill out a grievance form regarding the missing dentures and did not follow up with the family with a resolution. SSD C indicated the nurse and CNA who discovered the missing dentures should have filed a grievance for R5 or on her behalf. On 6/7/23 at 3:20 PM CNA L (Certified Nursing Assistant) indicated if Residents report missing an item she tells the floor nurse who will then fill out a grievance form for the resident. CNA L indicated anyone can fill out a grievance, including CNAs, nurses, other staff, and residents. On 6/7/23 at 3:27 PM RN J (Registered Nurse) indicated when a resident reports a missing item a grievance form should be filled out. RN J indicated he also would report this to NHA A. On 6/7/23 at 3:31 PM LPN K (Licensed Practicing Nurse) indicated when a resident is missing an item she tells SSD C about it and a grievance is filled out. On 6/7/23 at 4:00 PM NHA A indicated when resident's items are found to be missing a grievance form should be filled out for them and SSD C, NHA A, and DON B would start an investigation. NHA A indicated he was aware R5 was missing her dentures. NHA A indicated he did not fill out a grievance form for the missing dentures.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46863 Based on interview and record review the facility did not ensure that CNA (Certified Nursing Assistant) staff receive a performance evaluation at least every 12 months for 3 of 5 CNAs (CNA S, CNA T, and CNA Q) staff members randomly selected for review. -The facility did not provide performance evaluations for CNA S, CNA T, and CNA Q in the last employment year. -The facility did not provide regular in-service education to CNA S, CNA T, and CNA Q based on outcomes of their performance evaluation in the last employment year. This is evidenced by: The facility policy, entitled Performance Evaluations dated 6/10, states: The job performance of each employee shall be reviewed and evaluated at least annually . A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and least annually therefore after. On 6/2/23, at 9:15 AM, Surveyor requested the annual performance evaluations for CNA S, CNA T, and CNA Q from DON B (Director of Nursing). On 6/2/23, at 4:02 PM, Surveyor re-requested the annual performance evaluations for CNA S, CNA T, and CNA Q from DON B. On 6/2/23, at 4:20 PM during an interview with Surveyor DON B indicated that she was unable to find the annual performance evaluations for CNA S, CNA T and CNA Q. Example 1 CNA S was employed at the facility on 2/10/15. The facility did not have evidence that CNA S had a performance evaluation in the past 12 months. Example 2 CNA T was employed at the facility on 10/8/21. The facility did not have evidence that CNA T had a performance evaluation in the past 12 months. Example 3 CNA Q was employed at the facility on 7/28/21. The facility did not have evidence that CNA Q had a performance evaluation in the past 12 months.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on observation, interviews and record review, the facility did not ensure the facility provided pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 5 sampled residents (R18). R18 received short acting insulin greater than 15 minutes prior to a meal. Evidenced by: The facility policy titled, Insulin Administration, last reviewed 9/2014, does not include any information on when to give short acting insulin prior to meals. The facility policy titled, Diabetes Management, last reviewed 6/29/17, does not include any information on when to give short acting insulin prior to meals. According to drugs.com you should administer the dose of HUMALOG U-100 or HUMALOG U-200 within fifteen minutes before a meal or immediately after a meal by injection into the subcutaneous tissue. R18 was admitted to the facility on [DATE], following a hospital admission with diagnoses including Type 2 Diabetes Mellitus with diabetic polyneuropathy, Type 2 Diabetes Mellitus with nephropathy, Type 2 Diabetes Mellitus, obesity, anxiety disorder, CKD (chronic kidney disease) stage 4-5, and lymphedema. R18 was admitted to the facility with orders that include . Humalog Kwik Pen Subcutaneous Pen-injector 100 Unit/ML (milliliters) (Insulin Lispro), Inject 18 units subcutaneously two times a day for DM (Diabetes Mellitus). Lantus Solostar Subcutaneous Solution Pen-Injector 100 Unit/ML (Insulin Glargine), Inject 18 unit subcutaneously at bedtime for DM. On 6/07/23 at 11:19 AM, Surveyor observed LPN E (Licensed Practical Nurse) give R18 her Humalog 18 units prior to lunch. There was no snack given to R18 from time insulin was given and the time lunch was served. Surveyor made continuous observation of R18's room and meal was served to R18 at 12:38 PM. A total of 1 hour and 19 minutes from time insulin given to the time meal was served to R18. On 6/07/23 at 12:48 PM, Surveyor interviewed LPN E. Surveyor asked LPN E about R18's fast acting insulin administered for the lunch meal. LPN E stated, R18 gets insulin with each meal. Insulin is given according to the orders, the type of insulin ordered, and how soon the meal trays will be coming out. Fast acting insulin should be given no more than 15 minutes prior to the meal. Sometimes I give the insulin when the food is delivered. The kitchen is behind today. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/07/23 at 1:02 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how soon before a meal fast acting insulin should be given. DON B stated, Up to 15 minutes before. Meals should be served within that time frame. Today meals were late coming out I am not sure what was going on.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on interview, the facility did not assist the resident in making transportation arrangements to and from the source of service if the resident needs assistance for 1 of 3 Residents (R7) reviewed for transportation arrangements. R7 had an appointment with his Primary Care Physician (PCP). The facility refused to assist with transportation arrangements stating that R7 had elected to use their Medical Director as his PCP while in the facility. This is evidenced by: The facility policy titled Transportation, Social Services, revised December 2008, states in part: .Our facility shall help arrange transportation for residents as needed. 1.Except in emergencies, the resident or his or her representative (sponsor) shall be expected to arrange transportation (e.g., to outside physician or clinic appointments or for a planned transfer or discharge from the facility. 2. Social Services will help the resident as needed to obtain transportation . The facility's Admission Agreement states in part, .P. Choice of Physician and Physician Policy Notification: The facility wants you to feel comfortable with your medical care. To this end, each resident has the right and obligation under the law to select their own physician for the time he or she is a resident of this facility .At any time, the resident has the right to assign or replace a physician .This facility has obtained a medical director to act as a liaison with the physicians serving the facility's residents and to assist the facility on addressing any issue related to medical care . R7 was admitted to the facility on [DATE] with diagnoses that include: right above the knee amputation, sepsis, type 2 diabetes mellitus, toxic encephalopathy, and malignant neoplasm of the bladder. R7's most recent Minimum Data Set (MDS) dated [DATE] states that R7 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating that R7 is cognitively intact. R7's MDS also indicates that he required extensive assistance of 2 people for bed mobility and transfers. On 6/7/23 at 2:50 PM, Surveyor interviewed FM M (Family Member). FM M reported to Surveyor that R7 wanted to see his own PCP, so she scheduled an appointment on 1/23/23, and the facility refused to assist her with arranging transportation. FM M stated that R7 had not seen a physician since he had been at the facility. FM M stated that she asked the Social Worker to assist with arranging transportation and was told that they would not provide transportation, assist with arranging transportation, or help R7 get in or out of the car. (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/23 at 3:35 PM, Surveyor interviewed SW C (Social Worker). Surveyor asked SW C who is responsible for arranging transportation, SW C stated that she does not help with transportation. Surveyor asked SW C when a resident has an appointment with a PCP outside of the facility, what is your role in arranging transportation, SW C stated that they will not transport residents if they are seeing the facility's physician or nurse practitioner. Surveyor asked SW C if she would assist residents in arranging transportation, SW C stated that if they are going to see their PCP, then no. Surveyor reviewed the facility's policy with SW C. SW C stated that she had never seen that policy before. Surveyor asked SW C if she should be assisting residents with arranging transportation, SW C stated yes.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interview and record review, the facility did not ensure routine dental care was provided to 1 of 3 sampled residents (R5). R5's dentures were reported missing. The facility did not assist R5 in making an appointment or arrange transportation to and from the dental services location. The facility did not promptly, within 3 days, refer R5 (who lost her dentures), for dental services. The facility did not document the extenuating circumstances that led to the delay. The facility does not have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility. This is evidenced by R5 admitted to the facility on [DATE]. She had upper and lower dentures upon admission. R5's Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 9/12/22, indicates R5's cognition is moderately impaired with a Brief Interview for Mental Status (BIMS) score of 9 out of 15. R5's Nurse Notes, dated 9/10/22, include Resident's upper denture is missing .Meanwhile she will need a soft diet. R5's Nurse Notes, dated 9/11/22, include Resident ate less than 25% or refused meals for 24/hr. Client needs soft foods as she has lost her dentures. At breakfast today she ate her fill of oatmeal and applesauce On 6/6/23 at 3:28 PM, DON B (Director of Nursing) indicated it is not the responsibility of the facility to replace dentures. On 6/6/23 at 4:45 PM, SSD C (Social Services Director) indicated R5 could have wrapped her dentures up in a napkin and left them on her meal tray or threw them in the garbage. On 6/7/23 at 10:00 AM, SSD C indicated she investigated the missing dentures and discussed it with NHA A (Nursing Home Administrator), but they never found the dentures and NHA A indicated it was the fault of R5 for tossing her dentures away. R5 discharged on [DATE]. SSD C indicated the facility does not have a policy in place regarding missing dentures. SSD C stated she wanted to call and check in with R5 about her missing dentures, but NHA A advised her not to. Surveyor and SSD C reviewed the State Operations Manual at F790 noting the facility must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility and the facility must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days the facility must provide documentation of . the extenuating circumstances that led to the delay. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/23 at 4:00 PM NHA A (Nursing Home Administrator) indicated he was aware R5 was missing her dentures. NHA A indicated R5 is at fault for the missing dentures because she threw them away. NHA A indicated the facility does not have a policy in place for missing dentures and there was no follow up with R5 or her family completed regarding the missing dentures. NHA A, DON B (Director of Nursing), and Surveyor reviewed the State Operations Manual at F790 noting the facility must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility and the facility must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days the facility must provide documentation of . the extenuating circumstances that led to the delay. DON B and NHA A indicated they were not aware the facility needed a policy regarding lost or missing dentures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525330	A. Building B. Wing	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middleton Village Nursing and Rehab	6201 Elmwood Ave Middleton, WI 53562

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46863 Based on interview and record review, the facility did not ensure that nurse aides received required training hours and required dementia training for 2 of 5 Certified Nursing Assistant (CNA) staff members randomly selected for review. Two CNAs (CNA Q and CNA R) did not receive required training hours and required dementia training. Findings include: The facility policy, entitled Nurse Aide Qualifications and Training Requirements, dated 06/11, states in part: . Applicants who meet the qualifications for a nurse aide and are in training will have a minimum of 16 hours of training in the following areas prior to direct contact with the residents .dementia management. The facility policy, entitled Training Requirements Guideline, dated 5/29/20 states in part: Purpose: To inform and guide center leadership about training requirements and their role in the training development, implementation, and maintenance of an effective training program for all new and existing staff .At a minimum, training topics for all center staff must include: Dementia management and resident abuse prevention .The following additional training requirements are outlined for all nurse aides: .Must be no less than 12 hours per year . On 6/21/23 at 9:27 AM, Surveyor requested all training provided to CNA Q and CNA R in the last 12 months from DON B (Director of Nursing). At 2:46 PM Surveyor requested all training provided to include hours of training from DON B. CNA Q was employed by the facility on 7/28/21. Surveyor reviewed training documentation provided by the facility for CNA Q. Documentation indicated that CNA Q received 8 hours of training, not including dementia training. (It is important to note that the 12-hour training requirement is to include dementia management.) CNA R became employed by the facility on 6/20/22. Surveyor reviewed training documentation provided by the facility for CNA R. Documentation indicated that CNA R received 8 hours of training, not including dementia training. (It is important to note that the 12-hour training requirement is to include dementia management.)