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	05/06/2021

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

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on interview and record review the facility did not ensure consistency with the residents' right to receive visitors of his or her choosing at the time of his or her choosing for 1 of 24 sampled residents (R70) and 1 supplemental resident (R229). R229 was not allowed a visit with daughter after she had one the previous Saturday. The facility did not consistently implement the visitation policy or communicate this to family. This is evidenced by: The Facility's Policy and Procedure entitled Skilled Nursing Facility Visitation Guideline COVID-19, revised 4/28/21, documents in part: .Indoor Visitation .Residents in quarantine: whether vaccinated or unvaccinated, visitors should be prohibited for residents in quarantine until they have met criteria for release from quarantine . R229 admitted to the facility 4/20/21 with the following diagnoses: Acute respiratory failure, morbid (severe) obesity with alveolar hypoventilation, Asthma, Fracture of one right rib, generalized anxiety disorder and Dyspnea. R229 is alert and orientated x4 (to person, place, time and situation). Resident roster lists R229 in quarantine with a date of 5/5/21. (The date on the Resident Room Roster indicates when their 14 day admission quarantine ends.) Visiting log validates that R229's FM JJ visited 4/24/21 at 2:24 PM indoor at the facility. On 5/2/21 at 3:13 PM, Surveyor interviewed R229. Surveyor asked R229 how things were going for her in the facility, R229 stated angrily my daughter wasn't allowed to visit me yesterday (5/1/21). Surveyor asked R229 what time of day was it, R229 said visit was scheduled for 2:30-3 PM. Surveyor asked R229 why her daughter was not allowed to visit, R229 stated the person at the front desk said she couldn't visit because they didn't have a gown for her to where, but later the CNA's told me that I had 2 packages of gowns in my isolation cart outside my room, very upsetting and I'm just going to go home. (continued on next page)

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

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/4/21 at 9:12 AM, Surveyor interviewed R229's FM JJ (Family Member). Surveyor asked FM JJ if she could explain what happened on 5/1/21 when she attempted to visit, FM JJ explained that the lady at the desk said there weren't any gowns in the bin up front, so she went to look for a gown, when she came back 10 minutes later, she said there weren't any so I could not come in but if I wanted to visit with my Mom outside, they could bring her out; FM JJ said I had no idea if my Mom was even dressed to be able to come outside and by the time they would've done that, our visiting time would've been over, so I just called instead. Surveyor asked FM JJ what time was your visit scheduled for, FM JJ said 2:30-3 PM. Surveyor asked FM JJ if she knew why her Mom was so upset about this, FM JJ stated I believe Mom was more upset because they said there were no gowns available, and there were. Surveyor asked FM JJ if there was anything else she could think of related to visiting, FM JJ stated When I visited last Saturday (4/24/21), I had the same staff help me with no issues at all. On 5/4/21 at 12:24 PM, Surveyor interviewed RECP KK (Receptionist). Surveyor asked RECP KK if she worked Saturday 5/1/21, RECP KK said yes she did. Surveyor asked RECP KK if she recalled a situation where R229's FM JJ came to visit and was allowed to enter, RECP KK said yes. Surveyor asked RECP KK if she could explain what happened, RECP KK stated I do believe that was the situation where she wanted to come in, but I was told she couldn't come in because R229 was on isolation. Surveyor asked RECP KK if not having a gown was brought up, RECP KK said nothing mentioned about a gown. On 5/4/21 at 1:00 PM, Surveyor received a call from RECP KK. RECP KK stated I was thinking more about the situation and the cart didn't have gloves on it so I went to find a nurse, ran into ADON, IP V (Assistant Director of Nursing, Infection Preventionist) and she said R229 had to go outside to visit, that her visitor could not come in here to visit, that's where that came from. On 5/4/21 at 1:16 PM, Surveyor interviewed LPN U (Licensed Practical Nurse). Surveyor asked LPN U what the visiting policy is for residents that are in quarantine, LPN U said the residents that are in their 14 day admission quarantine are not allowed visitors until they are out of quarantine. On 5/4/21 at 1:48 PM, Surveyor interviewed ADON, IP V. Surveyor asked ADON, IP V what the visiting policy is for new admissions, ADON, IP V said the visiting policy for new admits are automatically in quarantine for 14 days unless they have been fully vaccinated, then there is no quarantine. Surveyor asked ADON, IP V for R229 who admitted [DATE], what should her visiting look like, ADON, IP V said indoor visiting is supposed to occur after the 14 day quarantine, no family is to come into the facility, but they can visit through window or on phone. Surveyor asked ADON, IP V if they could visit outdoors, ADON, IP stated we discourage residents from going outside to visit while they are on quarantine. Surveyor asked ADON, IP V if she could explain why R229's FM was allowed to visit in the facility on 4/24/21 and not on 5/1/21, ADON, IP V stated I'm not aware of that situation but the RECP KK questioned me about that on Saturday 5/1/21 and I explained that policy hasn't changed. Surveyor asked ADON, IP V if all staff should be aware of the visitation policy, ADON, IP V said yes, we have educated on it. On 5/6/21 at 9:00 AM, Surveyor interviewed ADON, IP V. Surveyor asked ADON, IP V if R229's FM JJ should have been allowed to visit in facility 4/24/21 and not 5/1/21, ADON, IP V said no, she should not have been allowed to visit indoors on 4/24/21. Surveyor asked ADON, IP V if she could explain why this occurred, ADON, IP V said she unsure who was here that day but the manager on duty should know who is on isolation and should not have indoor visitation, as the team discusses this daily, and the visitation times/schedule is made by the receptionists and/or SS Y. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/21 at 1:34 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if R229's FM JJ should have been allowed to visit in facility 4/24/21 and not 5/1/21, DON B stated no, we should be on the same page, I wasn't aware of this until now. Due to the facility staff were not following the visitation policy and were inconsistent in allowing visitation. This inconsistency caused confusion for R229 and FM JJ related to visitation. 34400 Example 2 R70 was admitted to the facility on [DATE]. R70 is receiving hospice care and has an activated POA (Power of Attorney) for health care. R70's significant change MDS (Minimum Data Set) indicated a BIMS (Brief Interview for Mental Status) score of 3 indicating severe cognitive impairment. On 5/4/21 at 7:32 AM, Surveyor interviewed R70's FM M (Family Member)/ POA on the phone. FM M explained she had been able to visit R70 in January, but R70 was upset about visits in the conference room, FM M wanted to visit R70 in R70's room. FM M stated the former NHA (Nursing Home Administrator) had told her on 2/14/21 not all staff had received their second dose of COVID-19 vaccine yet and she could not visit R70 in her room until this was completed, and NHA would let FM M know when FM M could come to R70's room for a visit. FM M stated she did not receive any further information from the former NHA regarding this. FM M stated she had made several requests to visit R70 in her room which were denied and this was upsetting to FM M. On 5/4/21 at 11:05 AM, Surveyor observed FM M visiting with R70 in her room. On 5/5/21 at 3:00 PM, Surveyor interviewed NHA A to asking if the facility had information regarding R70's visitation or communication with the family between 2/14/21 and the end of March. NHA A provided proof of a written agreement from 1/11/21 with FM M which allowed for Compassionate Care visits in a visiting area with FM M and R70. Visitation log notes, FM M had visited R70 on 1/12/21, 1/14/21, 1/19/21, and 1/21/21, the next visit was on 3/27/21. NHA also provided emails between former NHA and FM M through 2/3/21, these did not address any notification to FM M as to when staff had been fully vaccinated in the facility or when FM M would be able to visit R70 in her room. The facility was inconsistent in implementing the visitation policy and failed to communicate and/or allow visitation for R70 after 2/14/21.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on interview and record review, the facility did not ensure each resident received the necessary care and services in accordance with professional standards of practice to meet each resident's physical needs for 1 (R44) of 24 sampled residents. R44 had a change of condition on [DATE] and therapy requested an x-ray; the LPN (Licensed Practical Nurse) working did not consult R44's physician when alerted to the change in R44's condition and R44 did not get an x-ray until [DATE]. X-ray revealed an acute left femoral head dislocation. Resident went four days (,d+[DATE] to [DATE]) without consultation with a physician, during which time R44 had increased pain and altered mental status. This is evidenced by: The facility's policy and procedure entitled Notification of Change Guidelines, effective [DATE], 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. 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. Objective of the Notification of Change Guideline: The objective of the notification is to ensure that the facility staff makes appropriate notification to the physician and delegated Non-Physician Practitioner and immediate notification to the resident and/or the resident representative when there is a change in the resident's condition. 3. Tool for contacting Physician regarding a change in condition (CIC). (i). SBAR Evaluation - Situation, Background, Assessment, Response/Recommendation. (ii). Prepare the Evaluation through SBAR sections. (iii). Make recommendations you may have to the Physician. (iv). Document in the Response/Recommendations section the approved recommendations as well as any Orders received from the Physician. Notification is provided to the physician to facilitate continuity of care and obtain input from the physician about changes, additions to or discontinuation of treatment. Procedure for Notification of Changes for Resident. Procedure: 1. The nurse will immediately notify the resident, resident's physician and the resident representative(s) for the following (list in not all inclusive). If the resident's physician is not available contact the Medical Director. b .A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental or psychosocial status in either life threatening conditions or clinical complication. d. A need to alter treatment significantly. Per AMDA (American Medical Directors Association) guidelines, it states, in part: .an ACOC (acute change of condition) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death .When reporting information to a practitioner about a patient's condition, a nurse should not assume that the practitioner knows the patient well or can remember relevant details such as previous lab abnormalities or the patient's current medication regimen .Examples of Staff Roles and Responsibilities in Monitoring Patients With ACOCs .Staff nurse *Recognize condition change early, *Assess the patient's symptoms and physical function and document detailed descriptions of observations and symptoms, *Update the charge nurse or supervisor if patient's condition deteriorates or patient fails to improve within expected time frame, *Report patient status to practitioner as appropriate . (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Example 1 R44 admitted to facility, on [DATE], following hospitalization for left hip fracture repair. R44 is a DNR (does not want CPR (cardio-pulmonary resuscitation). R44 had the following diagnoses: left hip pain, falls, dizziness and giddiness, cognitive communication deficit, presence of left artificial hip joint, and a history of hip dislocation on [DATE]. R44 has an AHCPOA (Activated Healthcare Power of Attorney) and is not his own decision maker. Per R44's care plan, notes the following: Initiated [DATE] . Focus: The resident has limited physical mobility r/t (related to) left hip replacement with chronic dislocations. Interventions: Resident has weight bearing restriction (specify). Self-Propels Wheel Chair (Does not use foot pedals, ask resident to lift feet if pushing w/c (wheelchair). Provide supportive care, assistance with mobility as needed . Initiated [DATE] . Focus: The resident has actual chronic pain r/t left hip fracture with surgical fixation and chronic dislocations of same. Interventions: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Monitor/record/report to Nurse and s/sx (signs and symptoms) of non-verbal pain: Changes in breathing, Mood/behavior, etc. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. R44's Admission MDS (Minimum Data Set) dated [DATE] states in part . R44 requires extensive assistance of two staff members for bed mobility, transfers, toileting and hygiene. R44 also requires extensive assistance of one staff member for locomotion on and off the unit. BIMS (Brief Interview of Mental Status) score of 10, indicating moderate cognitive impairment. Nurses Notes dated [DATE] at 6:36 PM, it document in part . Resident is able to feed self, transfer x1 (times) assist with reminders to use call light, dsg (dressing) and other adls (activities of daily living) is assist x (does not indicate number of people used for assist) with resident able to participate. Nurses Notes dated [DATE] at 8:53 AM document in part . Resident s/p (status post) hip fracture repair. Resident is calm and pleasant able to voice needs and concerns, denies pain, has call light in reach. R44 had orders for Tylenol 1000mg (milligrams) by mouth TID (three times a day) for pain. Oxycodone 2. 5mg by mouth every 8 hours as needed for acute pain. ASA (Aspirin) 81mg chew tab. Note: R44 had not used Oxycodone since [DATE], while hospitalized . R44's eMAR (electronic Medication Administration Record) pain evaluation every shift indicates the following: [DATE]: NOC (night) shift, ,d+[DATE]. [DATE]: AM (morning) shift ,d+[DATE], PM (afternoon) shift , d+[DATE], and NOC shift ,d+[DATE] (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Nurses Notes dated [DATE] at 10:39 AM, it document in part . Cognition: Orientation: Person, place and time. The resident does not require supervision for safety. There has not been a change in the resident's baseline cognition. ADL Function: Resident requires partial/moderate assistance with walking, transferring, bed mobility, dressing, toileting and hygiene. R44's Physician's Note from [DATE] with APNP C (Advanced Practice Nurse Prescriber) states in part . Primary Discharge Diagnosis: Left Femoral Neck Fracture. Upon arrival to visit, patient sitting in chair outside of his room. States feels 'just fine.' He reports 'mild' pain to left femur/hip area. Pain is localized. Denies any numbness or tingling. Denies any calf pain. Just prior to visit he was independently ambulating down hallway, telling staff he wanted to leave facility. RN staff orientated. He was pleasant, cooperative and sat back in his chair without issues. Full ROS (review of systems) completed with patient and staff d/t (due to) cognition. Physical Exam: Extremities: LLE: Left hip abduction brace in place. LLE nonpitting edema 2+ (plus) from knee down to foot. DP (dorsalis pedis) pulse 2+. [NAME] sign negative. Neuro: Disoriented to situation. Moves all extremities spontaneously. Denies numbness and tingling. Assessment/Plan: Left cemented THA (total hip arthroplasty)-dislocated [DATE]. Last dose of oxycodone ,d+[DATE]. LLE 2+ nonpitting edema noted on exam today. LLE venous Doppler to r/o (rule out) DVT (deep vein thrombosis). Activity instructions per discharge summary: WBAT (weight bear as tolerated) TEDS (compression stockings used to reduce the risk of DVT) x2 weeks, hip abductor brace on at all times, maintain hip precautions. Pain thought to be contributing with behaviors at night while inpatient. No issues last night with pain. On [DATE] at 5:01 PM, it documents in part . New order taken for a venous Doppler study of LLE DX (diagnosis) edema on arrival to facility. Hx (history) of fx and dislocation to r/o DVT. Nurses Notes dated [DATE] at 10:31 AM document in part . Resident up in w/c, denied pain or discomfort, expressed to family he was in pain. Used PRN Oxycodone as ordered, when asking resident about pain he states, 'I don't know' but visual s/s (signs and symptoms) of pain present w/ (with) movement of LLE, working w/ therapy as well as transfers. L hip - surgical drsg (dressing) remains intact w/o striking present. R44's eMAR (electronic Medication Administration Record) pain evaluation every shift indicates the following: [DATE]: AM shift ,d+[DATE], PM shift ,d+[DATE], and NOC shift ,d+[DATE] Note: R44 had not used Oxycodone prior to this since [DATE] while still hospitalized . Pain was managed with TID Tylenol 1000mg. The physician was not consulted in regards to R44's increase in pain and nonverbal indicators of pain. Nurses Notes dated [DATE] at 3:30 PM document: Resident had Doppler completed on LLE. R44's Physical Therapy note dated [DATE] states in part . During transfer from WC (Wheelchair) to bed, pt (patient) was unable to stand, painful during weight shifting and need max A (maximum assist) for sit to stand and for stand pivot transfer. Pt was able to do all transfer and ambulation with CGA/min A (Contact Guard Assist with minimum assist) for safety yesterday during evaluation. Today, pt was unable to lift his Lt (left) leg and was complaining of pain and left leg was mildly internally rotated. Notified the same change to assigned nurse and recommended for Lt Hip x-ray to rule out dislocation. CNA (Certified Nursing Assistant) was educated on hip abduction brace and explained all hip precaution. Instructed to keep brace on all the time except during hygiene. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Note: The Nurse working did not follow through on contacting the physician per PT recommendations to rule out a dislocation in a resident with a known history of dislocation. The x-ray was not ordered as requested by the therapist resulting in a delay of treatment for R44. R44's Occupational Therapy note dated [DATE] states in part . OT (Occupational Therapy) noted patient was in WC and appeared stuck in the doorway; patient was asking for help. When OT asked what was the matter, patient indicated he 'couldn't move out of here because his L LE (left lower extremity) was 'stuck'. OT noted patient did not have foot pedals on WC or in room and patient was having difficulty picking up L LE to assist with propulsion (the action of driving or pushing forward). OT picked up patient's L LE to help him into the room, went to find elevating leg rests and fit to patient's L LE and had patient show her that he could propel in room with L LE slightly elevated. R44's eMAR (electronic Medication Administration Record) pain evaluation every shift indicates the following: [DATE]: AM shift ,d+[DATE], PM shift ,d+[DATE], and NOC shift ,d+[DATE] Nurse Notes dated [DATE] at 7:46 AM documents in part . Resident L hip-surgical, great bruising present to peri wound as expected, edema 2+ pitting, s/s of pain to LLE, resident denies pain verbally but shows pain w/movement, LLE r/o DVT [DATE], per radiology report good blood flow present w/o signs of DVT present, NP (Nurse Practitioner) notified. Note: During an interview with NP D she states that a message with Doppler results were left on her office voicemail and she did not receive it until [DATE]. This voicemail was left on a Saturday when the NP's was not in work status and the on call Physician was not notified of the results. Nurse Notes dated [DATE] at 4:23 PM document in part . Medication Administration Note: Oxycodone HCL Capsule 5mg give 0.5mg by mouth every 8 hours as needed for acute pain. Pain rating ,d+[DATE]. R44's eMAR (electronic Medication Administration Record) pain evaluation every shift indicates the following: [DATE]: AM shift NA (not applicable), PM shift ,d+[DATE], and NOC shift ,d+[DATE] Nurses Notes dated [DATE] at 4:41 AM document in part . Medication Administration Note: Oxycodone HCL Capsule 5mg give 0.5mg by mouth every 8 hours as needed for acute pain. Pain rating ,d+[DATE]. Nurses Notes dated ,d+[DATE] at 4:16 PM document in part . Medication Administration Note: Oxycodone HCL Capsule 5mg give 0.5mg by mouth every 8 hours as needed for acute pain. Pain rating ,d+[DATE]. R44's Physical Therapy note dated [DATE] states in part . Attempted several times to initiate PT today. Pt displayed increased confusion and unable/refuses to follow directions. Abductor brace not on, provided pt education that he needs to be wearing it. R44's eMAR (electronic Medication Administration Record) pain evaluation every shift indicates the following: [DATE]: AM shift ,d+[DATE], PM shift ,d+[DATE], and NOC shift ,d+[DATE] R44's eMAR (electronic Medication Administration Record) pain evaluation every shift indicates the following: [DATE]: AM shift ,d+[DATE], PM shift ,d+[DATE], and NOC shift ,d+[DATE]. Note: R44 received Oxycodone for pain on ,d+[DATE], ,d+[DATE] and twice on ,d+[DATE]. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Nurses Notes dated [DATE] at 2:01 AM document, Resident asleep in bed, no s/s of c/o pain, L Hip surgical, bruising continues, swelling noted as LLE is larger than RLE (right lower extremity), floating heels as resident will allow. R44's Physical Therapy note dated [DATE] states in part . Assisted pt with placing abductor brace on L hip. Pt instructed on transfers and bed mobility wheelchair to bed. Provided continued pt education on needing to wear his L brace at all times. Discussed with PT about possible hip dislocation. Nursing states they will be ordering x-rays. Nurse Notes dated [DATE] at 9:10 AM document in part . SBAR-General: Situation: STAT (immediately) x-ray, 2-view XR (x-ray) left hip. Dx (Diagnosis): Internal rotation S/P (status post) left hip surgery per NP D. Signs and Symptoms: Left leg inverted upon assessment. Assessment: Left leg inverted with non-pitting edema to left foot. Returned to bed per therapist. Left leg splinted utilizing two pillows. Educated resident and staff on the importance of keeping left leg splinted. Recommendation/Response: STAT x-ray, 2-view XR left hip. Dx: Internal rotation S/P left hip surgery per NP D. Educated resident on orders received from NP for STAT x-ray of left hip. Denies pain/discomfort. On [DATE] at 9:25 AM documents, Writer spoke w/ therapy, request for XRAY OF L Hip, resident unable to BWAT (bear weight as tolerated), and call placed to NP D, notified of therapy findings, request for XRAY. Note: On [DATE] therapy noted a change in condition in R44 as resident was unable to lift his left leg, was complaining of pain and left leg was mildly internally rotated. Therapy appropriately notified the nurse and requested left hip x-ray to rule out dislocation in a resident with a history of dislocation the nurse failed to notify the physician. R44's clinical presentation and known history of dislocation warranted an immediate physician notification. The nurse did not notify the physician which delayed R44's treatment. The physician was not notified of R44's change of condition for 4 days. Nurses Notes dated [DATE] at 12:58 PM, R44's x-ray report states in part . Results: Femoral hardware with superior dislocation. Soft tissue swelling. No fracture. Conclusion: Acute left femoral head dislocation. Nurse Notes dated [DATE] at 3:48 PM document in part . Left hip/pelvis x ray results received. Acute left femoral head dislocation. Orders per NP D to send to Hospital ER (emergency room) for closed reduction. Resident denies pain or discomfort at this time. Rates pain ,d+[DATE] at present. Nurse Notes dated [DATE] at 4:37 PM document in part . Writer asked if resident had any falls recently. Resident stated, 'No.' Physical Therapy noted in the am (AM) that the resident was having difficulties with PT not able to bear weight on to left lower extremity. PT reported this to staff. R44's Ambulance Transport Notes dated [DATE] at 4:30 PM document in part . As the crew arrived, the patient's airway was patent, breathing was normal at room air, and the patient's hands were cold with oxygen saturation of 94%. The patient was oriented at A&OX3 (Alert and oriented to person, place and time) but did not have trouble communicating with the crew and the staff. According to the staff, the patient has left femoral hip dislocation and the patient was having a bracelet (sic) on the left hip. The patient was stable, and the patient was administered with Tylenol 3 times a day and one other pain medication. Pain is ,d+[DATE] in pain scale. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	R44's Hospital Notes dated [DATE] document in part . Dislocation, Hip - W/ Procedural Sedation. Diagnosis: Closed dislocation of left hip, initial encounter. Medications given: Propofol 10mg/mL IV BOLUS last given at 8:36 PM. Activity: Weight bear as tolerated left lower extremity. Hip abduction brace on at all times restricting hip flexion to a maximum of 40 degrees. No rotation, adduction, or abduction. When in bed must have , d+[DATE] pillows between legs to prevent adduction. On [DATE], it is documented in part . Altered Mental Status, Resolved. Diagnosis: Agitation. Delirium. Medications Given: Oxycodone HCL tab 5mg, last given at 6:35 AM. You have been seen for 'Altered Mental Status.' Altered mental status has many causes. Come more common causes are: Reaction to medicine (this can happen if too much pain or sedative medicine is taken). Your symptoms have gotten better or gone away completely. Nurses Notes dated [DATE] at 1:25 AM document in part . Patient came back from the hospital via ambulance approx. (approximately) 2215 (10:15 PM). Patient denies pain. The patient and staff were reminded to use extra caution during transfers due to the anesthesia medication that was given during the procedure. He does have a full immobilizer cast that he is to wear until [DATE] at follow up apt (appointment). As a result of this incident the facility had the following nurse's statements: A statement was written by LPN F on [DATE] and states, On [DATE], post AM shift; writer was approached by therapy asked if resident was 'having' x-ray, at that time I stated he was in the process of having a Doppler completed, no further interaction on this day. On [DATE] AM shift same therapist approached and asked where x-ray report was, writer then stated he had a Doppler completed not an x-ray. Then the therapist began to speak of changes, I then spoke with NP whom we both went to therapy to get a full assessment. The therapist never expressed any changes to LLE to writer. A statement was written by LPN E, it was undated and states, PT approached me on Friday, [DATE]th, 2021 in regards to a patient. I started my shift and had not gotten report. PT stated that a patient who used to walk with both legs was unable to walk now and would like an x-ray order. PT did not specify which patient or any additional details pertaining to the order however PT mentioned it was LPN F's patient. I went to find LPN F and tell her the message that the PT relayed to me. LPN F told me she knew you (sic) which PT was talking about and that an X-ray was already ordered for that patient. After that I went back to doing my duties. Note: When therapy reported this to the Nurse she did not contact the physician, which resulted in a delay of treatment and increased pain for R44. R44 had not taken any pain medication prior to [DATE] since his hospitalization on [DATE]. R44 had a history of left hip dislocation and this should have alerted the nurse to notify the physician for treatment orders. Note: Though the facility did education with Therapy on updating Nurse Management with a resident change of condition on [DATE], and also completed education to nursing staff on [DATE] on change of condition, the facility failed to identify this particular resident as a concern and did not educate all nursing staff on the need to contact the MD with a change of condition. (continued on next page)

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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 0580 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:19 PM, Surveyor interviewed DON B. Surveyor asked DON B to describe what happened between [DATE] and [DATE] with R44. DON B stated, LPN E told me that something was said in passing from therapy. She thought they were talking about the Doppler when PT said x-ray because they were already here doing the Doppler. Education was done with therapy because an in-service was already completed with Nursing. We looked at this as a communication problem with therapy and staff. A QAPI Plan was completed in which we educated all therapy staff on bringing any concerns to a Nurse Manager. I did not educate Nursing because I thought it was a therapy communication issue. When I interviewed LPN E and LPN F they stated that therapy did not specify information and that it was provided in passing. R44 was seen by the NP that day and she didn't identify a concern so I thought the Doppler was what was wanted. Surveyor asked DON B if an RN assessed R44. DON B stated, No, I thought since he had been seen by the NP she would have noted any concerns. Note: R44 was not seen on [DATE] but on [DATE], the day prior to therapy reporting concerns and changes in R44's mobility. On [DATE] at 2:22 PM, Surveyor interviewed NP D. Surveyor asked NP D about Doppler. NP D stated, When R44 was admitted he was seen by NP C. She noted increased edema with abduction brace in place and ordered a Doppler. I was not notified until [DATE] about the therapist's concerns. The facility left me a message about the Doppler results on my office voicemail on Saturday and I didn't get them until Monday ([DATE]). On [DATE] at 2:32 PM, Surveyor interviewed LPN E. Surveyor asked LPN E about concerns brought to her by therapy on [DATE] regarding R44. LPN E stated, When they came they were looking for LPN F. I told LPN F he needed an x-ray. LPN F told me she knew which patient and that an x-ray was already ordered. I had just started on [DATE] and was new to the facility. I thought it was already getting done, LPN F told me that. Note: Surveyor attempted to contact LPN F who no longer works in the facility on [DATE]. No return call received. On [DATE] at 2:36 PM, Surveyor interviewed PT K (Physical Therapist). Surveyor asked PT K to tell her about [DATE] and R44. PT K stated, I signed my note at the end of the shift but it was written earlier in the day. I reported to the assigned Nurse. When I saw the changes around 2:00 PM, I couldn't find anyone but when I saw LPN E I told her what I saw and that R44 needed an x-ray. She asked me what to do because she was new. I told her I didn't know and she should ask another Nurse. LPN E said 'okay.' That was on Friday and I don't work on Saturday and Sunday. R44 was not on my schedule on Monday but on Tuesday when I saw him I asked the Nurse about the x-ray. That Nurse told me that they had done a Doppler. I then went and talked with DON B and asked her why an x-ray was not done. DON B said they got mixed up and did a Doppler. I then asked that they get an x-ray. The main thing with R44 was that he was not able to bear the weight that he had previously been able to do. The x-ray then showed a dislocation. R44 had a change of condition this was reported to Nursing by Therapy who requested an x-ray be completed. The physician was not notified of Therapy concerns and request for x-ray. R44 had a change of condition and the facility failed to immediately notify the physician with the concerns.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 30992 Based on record review, resident and staff interviews, the facility did not develop and implement a Comprehensive Resident-Centered Care Plan for 1 of 24 sampled residents reviewed (R50). R50 is moderately cognitively impaired and has a diagnoses including hemiparesis and hemiplegia following a stroke. When R50's Physical Therapy (PT) and Occupational Therapy ended, therapy provided R50 with exercises she should do on her own as the facility does not have a Restorative Program. These exercises were not added to R50's care plan to ensure staff provided verbal cues to perform her exercises. This evidenced by: R50 was admitted to the facility, on 12/18/20, with diagnoses including, but not limited to, cerebral infarction due to thrombosis of unspecified cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease, atrial fibrillation, cognitive communication deficit, osteoarthritis, major depressive disorder and muscle weakness. R50's Quarterly MDS (Minimum Data Set), dated 3/26/21, indicates R50 has clear speech, makes self-understood and usually is able to understand others. R50's BIMS (Brief Interview of Mental Status) is 8 out of 15, indicating she is moderately cognitively impaired. R50 requires 2+ person extensive assist for transfers, mobility, and toileting. R50 requires extensive assist of 2 for bed mobility and toileting and has no functional limitation/impairment in ROM on her upper extremities and impairment on one side of her lower body. Section O - O0500 Restorative Nursing Programs indicates R50 is not receiving any restorative care. R50's Care plan, R50 has actual for an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) CVA (cardiovascular accident / stroke) with hemiplegia, Date Initiated: 12/18/20; Goal: The resident will maintain current level of function in transfer and mobility through the review date. The resident will demonstrate the appropriate use of enabler bars to increase ability in bed mobility through the review date, *Date Initiated: 5/3/21. Interventions: Bathing: Physical Assist, Date Initiated 4/3/21; Bed Mobility: Physical Assist, Date Initiated: 4/3/21; Dining: R50 is independent , Date Initiated 4/3/21; Dressing: Physical assist, Date Initiated 4/3/21; Toileting: R50 requires physical assistance with toileting, Date Initiated 4/3/21; *Bed Mobility: R50 uses enabler bars x2 to maximize independence with turning and repositioning in bed, Date Initiated: 5/3/21; Transfers: R50 requires physical assist with Hoyer lift transfer with a minimum of 2 staff assist, Date Initiated: 12/18/20; Encourage R50 to use bell to call for assistance, Date Initiated: 12/18/20; Monitor / document / report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function, Date initiated: 12/18/20; Praise all efforts at self-care, Date Initiated: 4/3/21; *PT/OT evaluation and treatment as per MD (Medical Doctor) orders, Date Initiated: 4/3/21 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R50 received OT (Occupational Therapy) from 12/20/20 - 3/4/21, PT (Physical Therapy) from 12/22/20 - 3/3/21 and ST (Speech Therapy) from 12/20/21 - 3/5/21. Therapy provided R50 with a sheet of exercises for her to do independently. These exercises were not added to her care plan so staff know to cue R50 to do the recommended exercises. On 5/06/21 at 10:36 AM, Surveyor spoke with R50. R50 stated that COTA NN told her to move her arms and shoulders but, it's painful to move my right shoulder. Surveyor asked R50 if she has specific exercises to do. R50 stated yes, but she cannot recall what they area. Note, Surveyor did not observe R50's theraband in the room. Surveyor asked R50 do CNA's help you to move your arms and legs. R50 Stated, No. Surveyor asked R50 do CNA's remind you to move your arms and legs. R50 stated, No. On 5/6/21 at 12:34 PM, Surveyor spoke with COTA NN (Certified Occupational Therapy Assistant). Surveyor asked COTA NN, when R50's therapy ended was she to get restorative care. COTA NN stated, unfortunately we don't have a true restorative program at the facility. COTA NN added, what we do at time of discharge from therapy if the residents stays in the facility is we provide them an exercise program for their upper and lower body. We use a theraband so they can do arm and leg exercises and always encourage them to get up and stay in wheelchair to keep their core and back engaged. Staff would go over exercise she could do on her own safely. Surveyor asked COTA NN do you think R50 would remember or understand to do these exercises. COTA NN stated, if she was given a theraband and it was in her line of sight she would remember otherwise she would need a cue to do exercising. On 5/6/21 at approximately 1:30 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B should exercises provided by therapy be carried over to the resident's care plan. DON B stated, Yes, I would expect that to be there.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, the facility did not ensure resident's with limited range of motion (ROM) and mobility maintained or improved function unless reduced range of motion/mobility was unavoidable based on the residents clinical condition for 1 of 24 residents reviewed for ROM/mobility out of 24 total sampled residents (R50). R50 has diagnoses including hemiparesis and hemiplegia following a stroke. R50's Physical Therapy ended 3/3/21 and Occupational Therapy ended 3/4/21. The facility does not have a Restorative Program and did not provide range of motion (ROM) to R50 to maintain the function gained while receiving Physical Therapy and Occupational Therapy. Subsequently, R50 experienced increased pain and decreased range of motion in her right shoulder as a result. OT OO (Occupational Therapist) indicated R50's limited ROM is mainly due to pain, when she does active or assisted ROM she can get that arm to move more. This evidenced by: Facility policy Restorative Nursing Guidelines, dated 10/1/19, states, in part: .Purpose: To ensure that a resident with limited range of motion receives appropriate treatment and services to include range of motion and/or to prevent further decrease in range of motion. Assessment for Mobility: 1. Based upon the comprehensive assessment, the resident's care plan must include specific interventions, exercises and/or therapy to maintain or improve the ROM and mobility, or to prevent, to the extent possible, declines or further declines in the resident's ROM or mobility. The comprehensive assessment must identify the current status of the resident's ROM and mobility capabilities, which must be used to develop interventions. The decision on what type of treatments includes an evaluation of the cognitive ability of the resident to be able to independently participate, whether the resident requires assistance due to medical condition or cognitive impairments or loss of ability to follow treatment instructions. Care plan interventions may be delivered through the facility's restorative program, or as ordered by the attending practitioner, through specialize rehabilitative services. R50 was admitted to the facility, on 12/18/20, with diagnoses including, but not limited to, cerebral infarction due to thrombosis of unspecified cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease, atrial fibrillation, cognitive communication deficit, osteoarthritis, major depressive disorder and muscle weakness. R50's Admission MDS (Minimum Data Set), dated 12/24/20, indicates R50 has clear speech, makes self-understood and usually is able to understand others. R50's BIMS (Brief Interview of Mental Status) is 12 out of 15, indicating she is cognitively intact. Section G indicates R50 is totally dependent and requires 2+ person extensive assist for transfers. R50 requires extensive assist of 2 for bed mobility and toileting and has functional limitation/impairment in ROM on one side of her upper body and lower body. Section O - O0500 Restorative Nursing Programs indicates R50 started receiving Occupational Therapy (OT) on 12/20/20 and PT (Physical Therapy) on 12/22/20. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R50's Quarterly MDS (Minimum Data Set), dated 3/26/21, indicates R50 has clear speech, makes self-understood and usually is able to understand others. R50's BIMS (Brief Interview of Mental Status) is 8 out of 15, indicating she is moderately cognitively impaired. R50 requires 2+ person extensive assist for transfers, mobility, and toileting. R50 requires extensive assist of 2 for bed mobility and toileting and has no functional limitation/impairment in ROM on her upper extremities and impairment on one side of her lower body. Section O - O0500 Restorative Nursing Programs indicates R50 is not receiving any restorative care. R50's Care plan, R50 has actual for an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) CVA (cardiovascular accident / stroke) with hemiplegia, Date Initiated: 12/18/20; Goal: The resident will maintain current level of function in transfer and mobility through the review date. The resident will demonstrate the appropriate use of enabler bars to increase ability in bed mobility through the review date, *Date Initiated: 5/3/21. Interventions: Bathing: Physical Assist, Date Initiated 4/3/21; Bed Mobility: Physical Assist, Date Initiated: 4/3/21; Dining: R50 is independent , Date Initiated 4/3/21; Dressing: Physical assist, Date Initiated 4/3/21; Toileting: R50 requires physical assistance with toileting, Date Initiated 4/3/21; *Bed Mobility: R50 uses enabler bars x2 to maximize independence with turning and repositioning in bed, Date Initiated: 5/3/21; Transfers: R50 requires physical assist with Hoyer lift transfer with a minimum of 2 staff assist, Date Initiated: 12/18/20; Encourage R50 to use bell to call for assistance, Date Initiated: 12/18/20; Monitor / document / report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function, Date initiated: 12/18/20; Praise all efforts at self-care, Date Initiated: 4/3/21; *PT/OT evaluation and treatment as per MD (Medical Doctor) orders, Date Initiated: 4/3/21 R50 does not have a comprehensive care plan for restorative care or any type of exercises recommended by therapy. R50 received OT (Occupational Therapy) from 12/20/20 - 3/4/21, PT (Physical Therapy) from 12/22/20 - 3/3/21 and ST (Speech Therapy) from 12/20/21 - 3/5/21. Note, from 3/6/21 - 4/28/21 R50 did not receive any restorative care. On 4/6/21, APNP D (Advanced Practice Nurse Practitioner) had an in person visit at the facility with R50 and documented the following note: Patient reports all therapies stopped a month ago and since then her strength/mobility and pain to R (right) shoulder have worsened. Reports staff don't get her up to wc (wheelchair) during the day, I just stay in bed all day. Reports frustration with not getting therapy. NP (APNP D) was NOT made aware of decline in mobility/function. Patient thought SNF staff were working to get her therapy again but hasn't heard anything. APNP D discussed with SS Y (Social Services) who reports patient reached her 100 days of covered therapy on 3/16/21 and hasn't received therapy since. Discussed restarting therapy under Part B but would need new orders. Discussed concern with patient decline and NP will be ordering PT/OT/ST (Physical Therapy/Occupational Therapy/Speech Therapy). On 4/29/21 R50's Occupational Therapy started. R50's assessments includes the following: Musculoskeletal System Assessment: *UE ROM (Upper Extremity Range of Motion) RUE (Right Upper Extremity) ROM = Impaired; LUE ROM = WFL (Within Functional Limits) (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*RUE ROM Shoulder = Impaired; Elbow /Forearm = WFL; Wrist=WFL; Hand=WFL AROM (R) Shoulder Flexion = 45 degrees; Extension = 10 degrees *RUE Strength = Impaired *RUE Strength Shoulder = Impaired; Elbow / Forearm = Impaired; Wrist = Impaired Contracture Functional Limitations due to contracture = No 4/29/20 OT's Exercise Prescription states as follows: Purpose: Purpose of Exercise = Range of Motion ROM Exercise details to address patient's ROM limitations; Will start with non-weighted work on R (right) shoulder, increase as patient tolerates. On 5/2/21 and 5/06/21, Surveyor spoke with R50. Surveyor asked R50 where her pain is. R50 stated she has pain in her right shoulder. R50 stated she has had pain in her shoulder since 1998 when she had a stroke. Surveyor asked R50 has your pain changed over the last few months. R50 stated, her PT and OT ended in March. R50 stated when she was receiving therapy and diathermy her pain was a 6 or 7 and now her pain is 10 every day. R50 stated her pain fades away some with Tylenol or aspirin. R50 stated COTA NN told her to move her arms and shoulders but, it's painful to move my right shoulder. Surveyor asked R50 if she has specific exercises to do. R50 stated yes, but she cannot recall what they area. Note, Surveyor did not observe R50's theraband in the room. Surveyor asked R50 do CNA's come in to help you move your arms and legs. R50 stated, No. On 5/6/21 at 10:58 AM, Surveyor spoke with SS Y and MDS Coordinator MM (MDS). Surveyor asked SS Y to tell me about the information shared with her regarding R50's therapy. R50 would question us when she would be able to receive therapy. SS Y stated this was a daily and weekly thing for a while. SS Y stated, R50 was not grumpy or upset. SS Y stated she went over insurance issues with R50 several times but she did not understand. At some point in time she reported this to APNP D. It was probably her last visit with APNP D asked me to call R50's son and explain the insurance issue. SS Y stated, for Part B type therapy the therapy dept. makes those requests. At one point in time I think the insurance company gave them one day. SS Y stated R50 is currently getting 5 days of PT & 5 days of OT per week. SS Y stated, the Therapy Department sent in a lot of information to get this therapy time for R50. Surveyor asked SS Y and MDS Coordinator if they have a Restorative CNA (Certified Nursing Assistant) at the facility that does range of motion with residents. SS Y stated, Not at the time, staffing was not allowing us to have a Restorative CNA. SS Y added, we have a lot more employees that are now employed directly by the facility and we will move forward with that program (Restorative). Surveyor asked is there any restorative care such as active or passive range of motion being done at the facility. SS Y stated, there are plans for a couple people but, the facility does not currently have a restorative program. MDS MM stated staff document any restorative type of activities that feeds through to the MDS. Note, R50's documentation indicates she is not receiving any restorative care / range of motion. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/21 at 12:34 PM, Surveyor spoke with COTA NN (Certified Occupational Therapy Assistant) who is also the acting Director of Rehab. Surveyor asked COTA NN the dates that R50 received therapy. COTA NN stated, R50 received OT (Occupational Therapy) from 12/20/20 - 3/4/21, PT (Physical Therapy) from 12/22/20 - 3/3/21 and ST (Speech Therapy) from 12/20/21 - 3/5/21. COTA NN stated at the time R50's therapy benefit was exhausted, her AROM (active range of motion) in her right shoulder at the time of discharge was 45 degrees, she still complained of pain. At R50's time of discharge she was getting relief from diathermy and had a goal of ultrasound. Diathermy was most effective for R50. COTA NN stated in R50's note, the d/c summary doesn't state what she can do with PROM. Surveyor asked COTA NN, why did R50's therapies end. COTA NN stated, she exhausted her benefits & there was a waiting period to get the second insurance to pick back up. Note, APNP D brought this to the attention of the facility on 4/8/21 that was taking a while so we went ahead & got a Physicians Order and started treating her again. COTA NN stated, We didn't want her to decline any further than she already had, she had been making gains towards the end of therapy and didn't want to lose what she had gained and to decline from that point. After obtaining Physician Orders we submitted the request to insurance again. COTA NN stated, Therapy started again 4/29/21. Surveyor asked COTA NN, did insurance approve R50's therapy. COTA NN stated, it's still out in pending land, but the facility started therapy again. COTA NN stated, I'm hoping it won't be denied because she needs it. Surveyor asked COTA NN, what gains R50 made while in PT the first time. COTA NN stated, when it comes to her transfer status she was making gains, she was a Hoyer transfer and got to a stand pivot with therapy. Prior to her being hospitalized she was SBA (stand by assist) or modified independent for almost all of her ADL's (Activities of Daily Living) so she was quite high level. COTA NN stated, she was hospitalized ,d+[DATE]-[DATE] due to COVID-19 and respiratory complications due to COVID-19. COTA NN stated, she was pretty high level functioning. COTA NN stated, after she was hospitalized she was totally dependent with bathing, toileting, lower body dressing, moderate assist for upper body dressing & minimum assist for hygiene & grooming. COTA NN added, she was pretty dependent when she returned from the hospital, COVID really took a toll on her. COTA NN stated, R50 was still a Hoyer upon discharge from therapy. She went from total dependency to max assist for bathing so she improved a little bit there. For lower body dressing she went from total dependency to max assist. For toileting she went from total dependent to max asst. Upper body went from moderate to min. assist. COTA NN reviewed R50's PT notes. R50 had a goal to transition from supine to edge of bed. When R50 came in she was a max assist and her goal was to get to min of mod assist. She met that goal in February 2021. R50 has another goal to increase dynamic sitting balance from fair minus. On admission it was poor plus (COTA NN clarified, that is very bad.) That was again in February 2021, so she was steadily making good gains. Another goal is R50 will complete sit to stand transfers with SBA (stand by assist). That probably would have been her bed or wheelchair height, which was started in February. Standing didn't start until mid-February it took her a while to get her legs strong enough and her core ready. She was able to stand at time of discharge at the parallel bars at mid-mod assist. Fifty (50) % of the work was done by the therapist. She was getting close but we don't like to change resident transfers status unless they are safe each and every time we work with them. R50 started transferring 2/20 & was only working on sit to stand 2 weeks and that's not a lot of time in our opinion. COTA NN stated, that's not enough time to go from the Hoyer to the ez stand. PT was not comfortable with her doing ez stands transfers with nursing staff. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked COTA NN, when R50's therapy ended was she to get restorative care. COTA NN stated, unfortunately we don't have a true restorative program at the facility. COTA NN added, what we do at time of discharge from therapy if the residents stays in the facility is we provide them an exercise program for their upper and lower body. We use a theraband so they can do arm and leg exercises and always encourage them to get up and stay in wheelchair to keep their core and back engaged. Staff would go over exercise she could do on her own safely. Surveyor asked COTA NN do you think R50 would remember or understand to do these exercises. COTA NN stated, if she was given a theraband and it was in her line of sight she would remember otherwise she would need a cue to do exercising. Surveyor asked COTA NN, should R50 have been on a restorative program when her therapy ended. COTA NN stated, Yeah, oh yeah, she would have definitely benefited from a restorative program. Surveyor asked COTA NN is R50's right shoulder contracted. COTA NN stated, when I've seen her it doesn't look like a contracture, she can put her arms up when in therapy. COTA NN added, I think it's a combination of weakness and pain from the CVA (stroke). COTA NN stated, a Restorative Program would prevent R50 from having a decline in function so whatever gains are made during therapy they wouldn't be lost. COTA NN stated, a restorative program would be beneficial for contracture prevention, monitoring splints, making sure splints are on correctly, donning and doffing correctly and making sure residents stay as mobile as possible. Surveyor asked COTA NN, could a restorative program have prevented R50's decline in mobility and shoulder pain. COTA NN stated, Yes, a restorative program is never a bad thing. On 5/6/21 at 1:17 PM, Surveyor spoke with COTA NN. COTA NN stated she spoke with OT OO and confirmed there's no diagnosis of contracture in R50's right arm. COTA NN stated OT OO determined R50's limited ROM is mainly due to pain; when R50 does active or assisted ROM (range of motion) she can get that arm to move more. Surveyor spoke with OT OO who confirmed this information. On 5/6/21 at approximately 1:30 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B if a resident is receiving PT and OT and their therapy ends, would you expect them to be on a restorative program. DON B stated, it depends on the patient and how improved they are and if they need restorative. Surveyor asked DON B does the facility have a restorative program. DON B stated that CNA's assist residents, however, the facility does not have a restorative program. Surveyor asked DON B should exercises provided by therapy be carried over to the resident's care plan. DON B stated, Yes, I would expect that to be there. Surveyor asked DON B, why is that important. DON B stated, to increase the resident's maximum independence and functional ability. Surveyor asked DON B should R50 have been receive restorative care.

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Middleton Village Nursing and Rehab	6201 Elmwood Ave Middleton, WI 53562

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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 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** 39713 Based on interview and record review, the facility did not ensure that residents are free of any significant medication errors for 2 (R13 and R64) of 24 sampled residents. R13 was given medications on multiple occasions outside the physician ordered parameters. R64 did not receive her scheduled weekly insulin injection on [DATE]. This is evidenced by: The facility did not provide Surveyor their current medication administration policy. According to drugs.com, Midodrine works by constricting (narrowing) the blood vessels and increasing blood pressure. Midodrine is used to treat low blood pressure (hypotension) that causes severe dizziness or a light-headed feeling, like you might pass out. R13 was admitted to the facility on [DATE]. R13 is a full code (wanting CPR (Cardiopulmonary Resuscitation) in the event the heart stops). R13 has the following diagnoses: Moyamoya Disease (disease in which certain arteries in the brain are constricted), Occlusion and Stenosis of bilateral carotid arteries, Cerebral Ischemia (insufficient blood flow to the brain the meet demand). R13's admission orders indicate the following: SBP (Systolic Blood Pressure) Goal ,d+[DATE] call PCP/NP (Primary Care Provider/Nurse Practitioner) is SBP less than 130 or greater than 200. First date: [DATE]. Midodrine HCL (Hydrochloride) tablet 2.5mg (milligrams). Give 2.5mg by mouth two times a day for Essential HTN (Hypertension). Hold dose IF SBP greater than 150. Per R13's care plan, the following is documented: Initiated [DATE] . Focus: The resident has midodrine as ordered for blood pressure drops. Interventions: Give medications as ordered. Monitor for side effects and effectiveness. Monitor vital signs (as ordered, update MD (Medical Doctor) of significant abnormalities) R13's Quarterly MDS (Minimum Data Set) dated [DATE] states in part . R13 requires extensive assistance of one for transfers, toileting, hygiene and locomotion on and off the unit. R13 requires extensive assistance of two for bed mobility. BIMS (Brief Interview of Mental Status) score of 9, indicating moderate cognitive impairment. R13 has an AHCPOA (activated healthcare power of attorney) and is not her own decision maker. R13's eMAR's (electronic Medication Administration Record) indicates the following: R13 received Midodrine in March outside of physician ordered parameters on the following dates . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 8:00 AM, BP ,d+[DATE] [DATE] at 8:00 AM, BP ,d+[DATE] [DATE] at 8:00 AM, BP ,d+[DATE] and 12:00 PM, BP ,d+[DATE] [DATE] at 12:00 PM, BP ,d+[DATE] R13 received Midodrine in April outside of physician ordered parameters on the following dates . [DATE] at 8:00 AM, BP ,d+[DATE] [DATE] at 8:00 AM, BP ,d+[DATE] [DATE] at 12:00 PM, BP ,d+[DATE] [DATE] at 8:00 AM, BP ,d+[DATE] [DATE] at 12:00 PM, BP ,d+[DATE] [DATE] at 8:00 PM, BP ,d+[DATE] [DATE] at 12:00 PM, BP ,d+[DATE] [DATE] at 8:00 AM, BP ,d+[DATE] [DATE] at 8:00 AM, BP ,d+[DATE] [DATE] at 8:00 AM, BP ,d+[DATE] [DATE] at 8:00 AM, BP ,d+[DATE] Note: SBP noted on the above dates to be above the 150. Physician's orders indicate to hold if SBP greater than 150. On [DATE] at 10:00 AM, Surveyor interviewed LPN P. Surveyor asked LPN P about R13's orders for Midodrine. LPN P stated she is new to the facility and did not realize she had parameters for getting this medication. On [DATE] at 10:27 AM, Surveyor spoke with IDON B asking about R13's orders for Midodrine. IDON B stated that she was not aware that staff had been giving the medication outside of the Physician ordered parameters. IDON B said she would investigate and take care of this. The facility failed to ensure R13's medication was given as ordered by the Physician. 38725 Example 2 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R64 admitted to the facility [DATE] with the following diagnoses: Severe persistent asthma, Tobacco use, Acidosis, Migraine, and Type 2 Diabetes mellitus with Diabetic neuropathy. R64's most recent full MDS (minimum data set) assessment dated [DATE] documents a score of 14 on R64's BIMS (Brief Interview of Mental Status) which indicates she is cognitively intact. R64 had the following Physician Order dated Dulaglutide Solution Pen-injector (Trulicity) 0.75 MG (milligram)/0.5 ML (milliliter), Inject 0.5 ml subcutaneously one time a day every Mon (This medication is a weekly insulin injection). R64's MAR (Medication Administration Record) documents on [DATE], R64 should have received this insulin. On [DATE] R64's MAR documents number 9, which on the key means see progress note. R64's Progress Notes were reviewed and there is no evidence of a Progress Note to explain why R64 did not receive her insulin injection as ordered. There is a Progress Note dated [DATE] that documents the following Informed NP (Nurse Practitioner) that resident did not receive her insulin injection at 8 am this morning because i had to order from pharmacy. After informing supervisor she located injection .BS (blood sugar) 161 at this NP okay with writer administering injection at this time Resident administered her weekly insulin injection at 11:53.Explained to resident that injection was in facility. [SIC] Pharmacy delivery confirmation for R64's Trulicity pen is dated [DATE]. On [DATE] at 8:31 AM, Surveyor interviewed R64. Surveyor asked R64 if she received her insulin on time, R64 stated the last time I was here, I didn't receive my insulin when I was supposed to. Surveyor asked R64 when she is supposed to receive her insulin, R64 said weekly. On [DATE] at 2:59 PM, Surveyor interviewed LPN FF (Licensed Practical Nurse). Surveyor asked LPN FF what she would do if she didn't have a medication she was to administer, LPN FF explained that she would look in the contingency first, the call Provider for substitute, or see if the pharmacy could send STAT (urgent or rush) delivery. On [DATE] at 10:33 AM, Surveyor interviewed POET GG (Pharmacy Order Entry Technician). Surveyor asked POET GG if she could verify the date R64's Trulicity injection was delivered to the facility, POET GG reviewed computer and stated it was delivered on [DATE], [DATE], and [DATE]. On [DATE] at 1:34 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B does she expect medication to be administered as ordered, DON B said yes. Surveyor asked DON B if she could explain the situation surrounding R64 not receiving her insulin on [DATE], DON B stated I wasn't aware she didn't get it. Surveyor asked DON B if the facility is unable to administer a medication, what should they do; DON B explained there is a process to follow, including calling the Provider to get an order.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 38725 Based on interview the facility did not employ and provide sufficient staff or support staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. This has the potential to affect all 62 residents residing in the facility. The facility did not have dietary staff to complete meal service so the facility ordered out pizza for dinner. This is evidenced by: On 5/4/21 at 2:59 PM, Surveyor interviewed LPN FF (Licensed Practical Nurse). Surveyor asked LPN FF if there was ever a time recently when pizza was ordered for all the residents for supper, LPN FF said yes, about 3 weeks ago, there were stacks of pizza, all cheese on the meal cart. Surveyor asked LPN FF how the pizza got ordered and paid for, LPN FF said my guess is NHA A (Nursing Home Administrator) put it on a credit card. Surveyor asked LPN FF what did the residents that require altered consistency food like pureed eat, LPN FF said I think someone was in the kitchen making burgers for pureed people. On 5/4/21 at 3:15 PM, Surveyor interviewed CNA EE. Surveyor asked CNA EE if there was ever a time recently when pizza was ordered for all the residents for supper, CNA EE said yes we did have pizza one night that was delivered. Surveyor asked CNA EE if she knew why the pizza was ordered, CNA EE stated I don't know why we had pizza though. Surveyor asked CNA EE what did the residents that require altered consistency food like pureed eat, CNA EE said pureed pizza, and I fed R68 pureed pizza. On 5/5/21 at 8:09 AM, Surveyor interviewed KS G (Kitchen Supervisor). Surveyor asked KS G if it were possible one evening recently no kitchen staff was here to work, KS G said yes, it is possible no staff were here. Surveyor asked KS G if no kitchen staff were here, how would the residents have food to eat, KS G replied if no one was here, management and nursing should have covered. Surveyor asked KS G if he was aware of an evening recently where pizza was ordered for all the residents to eat, KS G stated I'm not sure if that actually happened, but I heard the staff ordered pizza to feed everyone because no one was here. Surveyor asked KS G if pizza is a food that is safe to puree and feed to those with altered consistency diet requirements, KS G said yes, pizza can be pureed. On 5/6/21 at 1:34 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she was aware of an evening recently where pizza was ordered for supper because there was not kitchen staff here, DON B said NHA A ordered pizza, but there was someone in the kitchen to puree food. On 5/6/21 at 2:16 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if there was an evening recently where pizza was ordered for supper because there was not kitchen staff here, NHA A stated there was a dietary aide but no cook, the menu was for pizza so I just ordered pizza. Surveyor asked NHA A what did the residents that require altered consistency food like pureed eat, NHA A said the managers went into the kitchen and pureed for those that required pureed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on observation and interview the facility failed to provide food that is palatable and at a safe and appetizing temperature for 3 of 24 sampled residents (R64, R67 and R22) and 1 supplemental residents (R224). R224, R64 and R67 reported food is not paltable. R22 reported his food was usually cold when delivered to his room and indicated meal trays were not delivered timely. This is evidenced by: Example 1 Surveyor observed the following on 5/2/21 at 12:00 PM, a cart with four meal trays was delivered to Harbor hallway. All plates were covered but one. The uncovered plate belonged to R224, it had rice, broccoli and chicken teriyaki on it. On 5/2/21 at 12:03 PM, Surveyor interviewed R224. Surveyor asked R224 how the food is, R224 stated the food doesn't have any seasoning and it isn't always hot. Example 2 On 5/2/21 at 3:52 PM, Surveyor interviewed R67. Surveyor asked R67 how the food is, R67 stated the food is of poor quality and is always cold. Surveyor asked R67 if there was a specific meal this pertained to, R67 said supper is the worst. Surveyor asked if there were any certain items, R67 said no, it's all items. Example 3 On 5/3/21 at 8:29 AM, Surveyor interviewed R64. Surveyor asked R64 how the food is, R64 stated the food sucks, it's always cold. Example 4 R22 was admitted to the facility on [DATE]. R22 admission MDS notes a BIMS (Brief Interview for Mental Status) score of 15 indicating R22 is cognitively intact. On 5/2/21 at 4:01 PM, R22 reported to Surveyor that the food was usually cold when delivered to his room. On 5/4/21 at 9:06 AM, Surveyor asked if staff would heat up his food if he requested, R22 said staff would heat it up but he was tired of asking, as he gets cold food so frequently. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/21 at 1:34 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if all plates should be covered prior to service, DON B said yes it should be covered. Surveyor asked DON B what her expectation is for meal delivery DON B stated meals should be delivered timely so residents receive a hot meal.