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	10/25/2021

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and medical record review, facility staff did not provide care and treatment in accordance with professional standards of practice for 1 of 3 sampled residents (R1). R1 was admitted to the facility on [DATE] status post C4-7 (cervical vertebra 4-7) laminectomies. R1's hospital discharge orders indicate: Wound Care Instructions: Incision care: Cleanse daily. The facility has no documentation that staff were assessing and cleansing R1's surgical incision until 5/25/21 when NP D (Nurse Practitioner) noted R1's surgical incision was erythemic with an elevated fluctuant abscess on 5/24/21. On 5/25/21 R1 was started on Cipro, a broad-spectrum antibiotic, for an infection. R1 was re-hospitalized from 5/28/21 - 6/11/21 requiring additional IV (intravenous) antibiotic, abscess drainage, and surgical revision of the wound. In addition, the facility has no documentation of R1's surgical incision in his Admission Skin Assessment, MDS (Minimum Data Set) or Care Plan. This is evidenced by: The facility policy, Skin Management Guideline, revised 11/28/17, indicates in part, the following: Purpose: To ensure residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown. It is the practice of this facility to properly identify and evaluate residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. A comprehensive individual evaluation guides the: .Identification of the presence of skin impairment; Provides an ability for the facility to develop and implement a care plan that reflects each resident's identified needs; Identify interventions to stabilize, reduce or remove underlying risk factors An individualized plan of care will be developed upon admission, reviewed and updated quarterly and with a change in condition as needed. The plan of care will identify impairment and predicting factors; Inspection of skin daily with cares and weekly by a licensed nurse; Skin Care (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	13. Consult with the Physician/NP if the wound is deteriorating or increases in size. Re-evaluate plan of care as appropriate. R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, fusion of spine-cervical region, encounter for surgical aftercare following surgery of nervous system, diabetes mellitus type 2, dementia without behaviors and ischemic cardiomyopathy. R1's 5/18/21 hospital record indicates the following: Post cerv (cervical) incision: Clean, dry, intact, flat, no SQ (subcutaneous - meaning occurring under the skin) fluid collection/induration. R1's 5/19/21 hospital record prior to discharge indicate Incision: Edges well approximated R1's MDS (Minimum Data Set) assessment dated [DATE] notes a BIMS (Brief Interview for Mental Status) score of 15 indicating R1 is cognitively intact. Section M (Skin), Surgical wound is blank. R1 is his own person. R1's Comprehensive Care Plan includes in part: The resident has an alteration in neurological status (SPECIFY) (This is blank) r/t (related to) Date Initiated: 5/19/2. Goal: The resident will be able to function at the fullest potential possible as outlined by the interdisciplinary team through the review date. Interventions: Notify MD (Medical Doctor)/Responsible party of changes in neurological status. On 5/19/21 R1's hospital discharge instructions indicate: Discharge diagnosis: Stenosis of cervical spine with myelopathy (neurological impairment associated with spinal cord compression in the cervical region). Wound Care Instructions: Incision care: Cleanse daily As documented below, through interview, the facility did not add the order to cleanse daily to the Treatment Administration Record until 5/25/21. R1's Admission Skin assessment dated [DATE] indicates: 3. Skin Integrity: a. Does the resident have skin integrity concerns: No (Note, there is no indication of R1's surgical incision.) On 5/24/21, 5 days following R1's admission to the facility, NP D (Nurse Practitioner) assessed R1 during an inpatient visit. Chief Complaint: Laminectomy, surgical site infection Patient seen today for routine f/u (follow up), medication and disease management. His cervical incision is noted to be erythemic with elevated fluctuant abscess at superior aspect and erythema surrounding to inferior aspect. He reports some mild tenderness. He is afebrile. Skin comments: Neck surgical wound Surgical site infection: nursing made aware of appearance and instructed to contact surgeon for sooner f/u and treatment, surgeon deferred initiating treatment change until evaluation in AM. On 5/25/21 R1's McGeers Infection Symptom Tracking indicates the following: 1. Date symptoms observed: 5/25/21 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Name of Physician notified: NP D (Nurse Practitioner) 3. Date and Time Physician Notified: 5/25/21 7:00 PM 4. Responsible Part Notified: Yes 5. Daughter 6. Date and Time Party Notified: 5/25/21 at 7:17 PM E. Cellulitis/Soft Tissue/Wound Infection: Yes 2a. Cellulitis, Soft Tissue Wound, Decubiti (Pressure Ulcer): a. Presence of Pus at the wound, skin, or soft tissue site 2b. If not pus present - must have four of the following: (Indicated all of the following) Redness at the site, Swelling at the site, Tenderness or pain at site I. Any other infections: 1. Yes; 2. Describe: admitted to facility with noted oozing abscess to nape of neck; area reddened, tender to touch, painful to palpation with center core opened draining a yellowish thick fluid. ABT (antibiotics) initiated for noted abscess which has not subsided since admission which appears to have declined. There is no prior documentation that indicates R1 had an abscess upon admission or that it was draining a yellowish thick fluid. The facility's first assessment of R1's surgical incision is 5/25/21, six (6) days after admission. On 5/25/21 R1 had an appointment with PA E (Physician Assistant) at the clinic for a wound check. On physical exam today BP (blood pressure) 136/70, Temp (temperature) 97.3 F (Fahrenheit) (Axillary) he is seated in a wheelchair, but he is able to stand and takes a few shuffling steps with a stooped forward posture. Upper extremity strength testing does reveal 5/5 strength throughout. He does have some pain in his neck with deltoid testing. Incision overall appears to be healing well other than an area of the superior aspect of the incision that is approximately 2 cm (centimeters) across with a fluctuant fluid collection just below the surface of the skin. There is also an adhesive crust over the incision and that was peeled away carefully after being cleaned with iodine. A small opening was identified and clear serous fluid was expressed with gentle massage. No purulence was noted. A culture swab was obtained. Assessment and Plan: Status post C4-7 laminectomies about 2 weeks ago. Wound does not appear overtly infected although there was a small amount of fluid expressed from the most superior portion of the incision. Give the small opening and fluid collection, I will treat the patient with Cipro 500 twice a day for 5 days.He will follow-up as scheduled in neurosurgery clinic in about one month, but if any worsening symptoms were to occur in regards to his wound or he has any questions or concerns I encouraged him to contact neurosurgery office. He was here in clinic today with his daughter. On 5/25/21 at 7:14 PM, R1's progress notes indicate the following: Bacitracin Ointment 500 units/gram - Apply to cervical wound topically two times a day for wound care wash gently with soap and water, rinse, pat dry then apply bacitracin and cover with dressing. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/25/21 at 9:33 PM, R1's progress notes indicate the following: Resident started Cipro 500 mg, BID (twice a day). On 5/26/21 the facility assessed and measured R1's surgical incision for the first time. Wound Information: Status: Active, Type: Surgical, Classification: Incision, Source: Present on admission, Date identified: 5/19/21 Size: 1.50 x 1.30 x 0, Tissue Type: Pale Pink Non-granulating=100% (Note, the picture contained in this assessment demonstrates the surgical incision is reddened erythema surrounding the wound.) On 5/28/21 NP D assessed R1 during an inpatient visit. Chief Complaint: Discharge Planning Subjective: HPI: 70 y/o (year old) male patient with PMH (primary medical history) including stenosis of cervical spine with myelopathy, DM2 (diabetes mellitus type 2), dementia, HTN (hypertension), COPD (chronic obstructive pulmonary disease) recently hospitalized s/p (status post) C4-7 (cervical vertebra 4-7) laminectomies on 5/11/21. He was felt stable for discharge to SNF (skilled nursing facility) for (Sub-Acute Rehabilitation) on 5/19/21. During his stay he developed an infection to cervical incision site requiring I&D (incision and drainage) and initiation of antibiotic by surgeon on 5/25/21 with improvement. He was seen today for discharge planning at his request. His daughter is reportedly planning to stay with him at this time. He is recommended to discharge home with home health services for PT/OT/Nursing (Physical Therapy/Occupational Therapy). Skin Comments: Post neck incision well approximated with mild soft edema and erythema Assessment: Spinal stenosis: S/P C4-7 laminectomy. PT/OT eval and treat as indicated. Tramadol PRN (as needed) for pain. Seen by surgeon 5/25/21 d/t (due to) concern of infection, Cipro until 5/30/21 . On 5/29/21 at 2:27 AM, R1's H&P (History and Physical) indicate the following: .He followed up with NS (Neurosurgeon) on 5/25/21 and had fluid expressed out of his wound, was started on Cipro and went back to the facility for further rehab. ER workup revealed AKI (acute kidney injury) with a normal creatinine 2 weeks ago, now greater than 8. The patient was also hypotensive (72/50) in the ER. WBC (white blood cell count) is elevated along with procalcitonin, lactate. Assessment and Plan: AKI (Acute kidney injury)-normal creatinine 2 weeks ago, now 8.78; likely multifactorial including: prerenal, hypotension, medication related (Lisinopril, metformin, Chlorthalidone, Coreg). -Aggressive IVF (intravenous fluids), recheck in the am -Consider Nephrology consult if creatinine continues to worsen -Renal dose medications -UA (urinalysis) unremarkable Hypotension - improving with IVF, continue at 125 cc/hr. (hour) Elevated Lactate-likely secondary to hypotension, recheck (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Emergency Department orders are as follows: .0.9% NaCl injection 3ml - 0.9% NaCl injection 1-10ml -- Followed by -0.9% Nacl IV bolus -0.9% Nacl infusion -0.9% NaCl injection 3ml -0.9% NaCl injection 1-10ml -0.9% NaCl IV Bolus -clindamycin (Cleocin) 600 mg in 50 ml NACL IVPB (Intravenous piggyback setup) (This means medication is administered via secondary IV tubing connected to the primary tubing). S/P (status post) Laminectomy with recent drainage-just finished Cipro course, received Clinda (Clindamycin is an antibiotic) in ER. Will not continue antibiotics at this time, but with any change in condition would empirically treat . R1 was hospitalized from 5/29/21 - 6/11/21. R1's hospital noted dated 6/10/21 indicates the following: Procedure: Posterior cervical washout with re-approximation of fascia and drain placement. Pre-Op Diagnosis: Wound Dehiscence R1's hospital records dated 6/11/21 indicate the following: .His wound worsened with erythema, but still no fever or pain. It was opened at the bedside on 6/9/21 with copious serous drainage. On 6/9/21 R1 was taken to the operating room and underwent wound revision with closure of facial dehiscence. Following surgery, he continued to do fairly well, tolerating pain. We will plan on SNF (skilled nursing facility) transfer on POD#1(post-op day number 1) with drains in place and close follow up in clinic on Monday with Physician for wound check and likely drain removal. On 10/25/21 at 4:22 PM, DON B (Director of Nursing) indicated there is no Admission Skin Assessment for R1's surgical incision. On 10/25/21 at 5:00 PM, Surveyor spoke with DON B and DSS C (Director of Clinical Services). Surveyor asked DON B and DSS C if there is documentation for the Physician Orders to Cleanse daily for R1's surgical incision. DSS C stated there is no documentation to cleanse the surgical incision until orders were entered with Cipro on 5/25/21. Surveyor asked DON B and DSS C would you expect this to be documented and done. DSS C stated, Yes. Surveyor asked DON B why is it important to follow Physician Orders and cleanse the surgical incision daily. DON B stated, I can't speak to that. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 11/2/21 at 9:14 AM, Surveyor spoke with NP D. Surveyor asked NP D if she recalls R1. NP D stated, yes. NP D stated on 5/24/21 she went to the facility to see R1 for a routine visit. NP D stated the visit was routine and the facility did not notify of her of any concerns related to R1's surgical incision. NP D stated when she saw R1's surgical incision, It was clear it needed an antibiotic and I&D (incision and draining). NP D stated she remembers pushing hard for the nurse to call R1's Surgeon and she was not willing to take no for an answer. NP D stated R1's infected surgical incision should have been noticed by the staff and staff should have been monitoring and cleansing R1's incision. NP D stated she is a Wound Consultant and she can tell how long a wound/infection has been present and this infection was there for a couple of days prior to her visit. NP D stated this infection did not appear suddenly and if it had R1 likely would have gone septic quickly. NP D stated the fluid under R1's surgical incision needed to come out which required the I&D.