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	02/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Middleton Village (the)	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 0580 Level of Harm - Minimal harm or potential for 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** Based on interview and record review, the facility did not consult with the resident's physician when there was a change in the resident's physical condition or a possible need to alter treatment for 1 of 9 sampled residents (R7). R7 experienced an electrical shock when a light switch shorted out in her room, An RN never assessed R7 for injuries. R7's Medical Doctor was not consulted about the incident. This is evidenced by: Facility policy, entitled Notification of Changes Guideline, revised 7/24/19, includes, in part: .Procedure for notification of changes for resident . The facility shall promptly notify the resident . and his or her physician . of changes in resident's condition or status in order to obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences. The nurse will immediately notify the resident, resident's physician, and the resident representative for the following (list is not all inclusive). If the residents physician is not available contact the Medical Director. An accident involving resident, which results in injury and has the potential for requiring physician intervention. A significant change in resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complication. In life threatening conditions activate the emergency response system immediately .Document the notification and record any new orders in the resident's medical record. Educate the resident about the proposed plan to treat, manage, monitor the resident's change in condition . R8 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 12/9/19, indicates R8 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. R8 resides across the hallway from R7 and has become her friend. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/20 at 9:56 AM, during initial tour of the facility, R8 indicated R7 lived across the hallway from her and there is an electrical problem in her room that has not been addressed or reported. R8 indicated R7 was visually impaired and while R7 was reaching for something that was plugged in, she was electrocuted and burned on her left hand. R8 indicated R7's hand was covered in a black soot. R8 said R7 came to her after this happened and R8 is the one who called LPN J (Licensed Practical Nurse). R8 pointed towards her nightstand that had several outlets built into the left side panel. R8 also pointed to a beaded metal cord light switch on the wall above the nightstand that hung down and the end of it was lying on the nightstand. Approximately 4 inches to the right of the light switch cord was the call light cancel button. R8 concluded the conversation stating, I ask staff about this. LPN J told me it doesn't concern me. It does concern me if the house [CONDITION(S)] down. It worries me. R7 was admitted to the facility on [DATE], with diagnoses, including: chronic pain, [CONDITION(S)] of bilateral knees, [CONDITION(S)] in one eye, and Diabetic Retinopathy. Her most recent MDS, with ARD of 1/15/20, indicates R7 is cognitively intact with a BIMS score of 14 out of 15. On 2/4/20 at 10:05 AM, during an interview, R7 indicated that she received an electric shock from a switch in her room and has a sore on her left hand. Surveyor observed a moon shaped scab approximately a quarter of an inch long on the outside, back of R7's left hand. R7 was in the middle of therapy and made arrangements with Surveyor to meet later in the day. On 2/4/20 at 3:02 PM, during an interview LPN J indicated R8 and R7 called her. She noticed R7 had black soot or black dust on her left hand and R7 indicated to her that she was electrocuted on her hand and she saw a light go through the wall, all while messing with her charging cord and metal pull cord. LPN J stated, She is blind. I was like how could you see anything? She didn't see nothing. I used a wet washcloth and soap to wipe the black dust, soot stuff off her hand. Her skin was dry, intact, and clean. Her vitals were fine. I knew she didn't see nothing. No shock. No pain. I was not concerned. LPN J indicated she did tell RN K (Registered Nurse) and MM E (Maintenance Man). R7's nurse note, dated 1/27/20 at 6:42 PM, includes: Resident in room. Denied pain or discomfort to hands. Black dust like present to left hand. Vital signs stable. Skin clean, dry, and intact. On 2/4/20 at 3:06 PM, during an interview, RN K indicated LPN J did report the incident to her. RN K indicated she asked LPN J what she did about it to which LPN J replied she checked R7's skin, the environment, R7's vitals. RN K stated, No injury was noted. No residual pain. Surveyor then asked RN K if she assessed R7. RN K stated, I did not go look at (R7) or assess her. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/20 at 3:12 PM, Surveyor brought a second RN Surveyor to observe R7's scab on her hand. Surveyor asked R7 if she was blind all of her life. R7 stated, No. I can see shapes, colors, and shadows still. I can see enough to know you are wearing a white sweater with black stripes. I just can't make out the details of your face. (It is important to note Surveyor was wearing a white sweater with black stripes.) R7 pointed at the beaded metal switch cord that hung down and laid resting on her nightstand. She indicated the cord broke when she received the shock that sent her backwards in a hurry. Surveyors observed the broken off piece of the metal cord under R7's bed, on the floor. R7 stated, I saw blue, red, and orange flash across the wall at the same time I felt the shock run right through my hand and arm. R7 said she let go immediately of the metal cord then. R7 indicated since the incident she has experienced more pain at night, her hand has been falling asleep and she can't wake it up, and today (2/4/20) she had trouble holding her bingo chips. R7 also indicated she had not seen her MD for this and she would like to. Surveyor asked if the cord was for just one light above R7's bed or both. R7 indicated she thought both, but was not sure. On 2/4/20 at 4:30 PM, during an interview, DON B indicated LPNs do not assess residents and she was unaware R7 reported that she received an electrical shock. DON B indicated it is her expectation when any staff member is made aware of a safety concern they report it to her, have an RN assess resident, notify resident's medical doctor (MD), and have MM E ensure environment is safe. DON B indicated RN K should have assessed R7 for injury, notified R7's MD, and reported the incident to DON B and/or NHA A. DON B indicated MM E should have also been notified by LPN J and/or RN K. NHA A entered room and joined conversation, stating that she was unaware R7 reported this incident until now and RN K should have assessed resident, R7's MD should have been notified R7 should have been offered a different room, and MM E should have been involved. On 2/4/20 at 5:10 PM, R7 stated her pain is normally at a 6 out of 10 due to her arthritis, but since the event it has been between 7-9 out of 10 at night and her sleep has been interrupted due to the pain. R7 also indicated she struggled to hold her bingo chips today. R7 stated, It feels like it is tingling or shutting off circulation. It is very, very painful, like the hand and arm are going to sleep. You keep trying to wake it up but can't.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure the residents' environment remained as free of accident hazards as possible for 1 of 9 residents reviewed (R7), who experienced an electrical shock when a light switch shorted out in her room, An RN never assessed R7 for injuries. R7's Medical Doctor was not notified of the incident, and the short was never repaired so R7 continued to be at risk for a similar incident occurring. Since being shocked, R7 has experienced more pain in her hand and complains of her hand falling asleep. The facility's failure to ensure a safe environment in R7's room created a finding of immediate jeopardy that began on 1/27/20. The Nursing Home Administrator (NHA A) and Director of Nursing (DON B) were notified of the immediate jeopardy on 2/5/20 at 9:55 AM. The immediate jeopardy was removed on 2/4/20. The deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its plan of correction. This is evidenced by: According to https://ehs.[NAME].edu/book/export/html/75, The major hazards associated with electricity are electrical shock, fire and arc flash. Electrical shock occurs when the body becomes part of the electric circuit, either when an individual comes in contact with both wires of an electrical circuit, one wire of an energized circuit and the ground, or a metallic part that has become energized by contact with an electrical conductor. The severity and effects of an electrical shock depend on a number of factors, such as the pathway through the body, the amount of current, the length of time of the exposure, and whether the skin is wet or dry. Water is a great conductor of electricity, allowing current to flow more easily in wet conditions and through wet skin. The effect of the shock may range from a slight [NAME] to severe [CONDITION(S)] to [CONDITION(S)]. The chart below shows the general relationship between the degree of injury and amount of current for a 60-cycle hand-to-foot path of one second's duration of shock. While reading this chart, keep in mind that most electrical circuits can provide, under normal conditions, up to 20,000 milliamperes of current flow. Current Reaction 1 Milliampere Perception level 5 Milliamperes Slight shock felt; not painful but disturbing 6-30 Milliamperes Painful shock; let-go range 50-150 Milliamperes Extreme pain, respiratory arrest, severe muscular contraction 1000-4,300 Milliamperes Ventricular fibrillation (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10,000+ Milliamperes [CONDITION(S)], severe [CONDITION(S)] and probable death According to OSHA, [CONDITION(S)] are the most common shock-related injury. An electrical accident can result in an electrical burn, arc burn, thermal contact burn, or a combination of [CONDITION(S)]. Of these, electrical [CONDITION(S)] are the most serious [CONDITION(S)] and require immediate medical attention. They occur when electric current flows through tissues or bone, generating heat that causes tissue damage. R8 lives across the hall from R7. R8 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. On 2/4/20 at 9:56 AM, during initial tour of the facility, R8 indicated there is an electrical problem in R7's room that has not been addressed or reported. R8 indicated R7 is visually impaired and while R7 was reaching for something that was plugged in, she was electrocuted and burned on her left hand. R8 indicated R7's hand was covered in a black soot.R8 said R7 came to her after this happened and R8 is the one who called LPN J (Licensed Practical Nurse). R8 pointed towards her nightstand that had several outlets built into the left side panel. R8 also pointed to a beaded metal cord light switch on the wall above the nightstand that hung down and the end of it was lying on the nightstand. Approximately 4 inches to the right of the light switch cord was the call light cancel button. R8 concluded the conversation stating, I ask staff about this. LPN J told me it doesn't concern me. It does concern me if the house [CONDITION(S)] down. It worries me. R7 was admitted to the facility on [DATE] with diagnoses, including: chronic pain, [CONDITION(S)] of bilateral knees, [CONDITION(S)] in one eye, and Diabetic Retinopathy. Her most recent MDS, with ARD of 1/15/2020, indicates R7 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. On 2/4/20 at 10:05 AM, during an interview R7, indicated that she received an electric shock from a switch in her room and has a sore on her left hand. Surveyor observed a moon shaped scab approximately a quarter of an inch long on the outside, back of R7's left hand. R7 was in the middle of therapy and made arrangements with Surveyor to meet later in the day. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/4/20 at 3:12 PM, Surveyor brought a second Surveyor to observe R7's scab on her hand. Surveyor asked R7 if she was blind all of her life. R7 stated, No. I can see shapes, colors, and shadows still. I can see enough to know you are wearing a white sweater with black stripes. I just can't make out the details of your face. (It is important to note Surveyor was wearing a white sweater with black stripes.) R7 pointed at the beaded metal switch cord that hung down and laid resting on her nightstand. She indicated the cord broke when she received the shock that sent her backwards in a hurry. Surveyors observed the broken off piece of the metal cord under R7's bed, on the floor. R7 stated, I saw blue, red, and orange flash across the wall at the same time I felt the shock run right through my hand and arm. R7 said she let go immediately of the metal cord then. R7 indicated since the incident she has experienced more pain at night, her hand has been falling asleep and she can't wake it up, and today (2/4/20) she had trouble holding her bingo chips. R7 also indicated she had not seen her MD for this and she would like to. Surveyor asked if the cord was for just one light above R7's bed or both. R7 indicated she thought both, but was not sure. Surveyor reached her hand out to pull cord and as soon as her hand touched cord, Surveyor felt a sudden painful shock in her hand and arm. Surveyor jolted backwards away from the cord. Surveyor also heard a snap sound when this happened. Second Surveyor and R7 both voiced that they heard the pop sound when Surveyor moved back rapidly. Second Surveyor observed R7's hand with a moon shaped scab on it and R7 stated it was a flash burn. On 2/4/20 at 3:02 PM, during an interview LPN J, indicated R8 and R7 called her. She noticed R7 had black soot or black dust on her left hand and R7 indicated to her that she was electrocuted on her hand and she saw a light go through the wall, all while messing with her charging cord and metal pull cord. LPN J stated, She is blind. I was like how could you see anything? She didn't see nothing. I used a wet washcloth and soap to wipe the black dust, soot stuff off her hand. Her skin was dry, intact, and clean. Her vitals were fine. I knew she didn't see nothing. No shock. No pain. I was not concerned. LPN J indicated she did tell RN K (Registered Nurse) and MM E (Maintenance Man). R7's nurse note, dated 1/27/20 at 6:42 PM, includes: Resident in room. Denied pain or discomfort to hands. Black dust like sud present to left hand. Vital signs stable. Skin clean, dry, and intact. On 2/4/20 at 3:06 PM, during an interview, RN K indicated LPN J did report the incident to her. RN K indicated she asked LPN J what she did about it to which LPN J replied she checked R7's skin, the environment, R7's vitals. RN K stated, No injury was noted. No residual pain. Surveyor then asked RN K if she assessed R7. RN K stated, I did not go look at (R7) or assess her. On 2/4/20 at 3:15 PM, Surveyor went to find MM E. During an interview MM E indicated he was unaware that a resident reported she had been shocked by an electrical switch in her room. MM E indicated he expects staff to notify him immediately of a concern like this because he would drop everything he is doing to fix it because this is a resident safety concern. MM E indicated to R7 he could get her a different room while he works or has someone work on her switch. R7 stated she has been avoiding the night stand altogether, especially the metal light cord and the call light cord. She indicated she worries about the house starting on fire. MM E took the face plate off of the switch and indicated that he will not touch this and he is going to call an electrician to come in. MM E stated, I know better than to touch this. Too many wires going into here for me. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/4/20 at 4:30 PM, during an interview, DON B indicated LPNs do not assess residents and she was unaware R7 reported that she received an electrical shock. DON B indicated it is her expectation when any staff member is made aware of a safety concern they report it to her, have an RN assess resident, notify resident's medical doctor (MD), and have MM E ensure environment is safe. DON B indicated RN K should have assessed R7 for injury, notified R7's MD, and reported the incident to DON B and/or NHA A. DON B indicated MM E should have also been notified by LPN J and/or RN K. NHA A entered room and joined conversation, stating that she was unaware R7 reported this incident until now and RN K should have assessed resident, R7's MD should have been notified R7 should have been offered a different room, and MM E should have been involved. On 2/4/20 at 5:10 PM, R7 stated her pain is normally at a 6 out of 10 due to her arthritis, but since the event it has been between 7-9 out of 10 at night and her sleep has been interrupted due to the pain. R7 also indicated she struggled to hold her bingo chips today. R7 stated, It feels like it is tingling or shutting off circulation. It is very, very painful, like the hand and arm are going to sleep. You keep trying to wake it up but can't. The facility's failure to ensure a safe environment in R7's room created a finding of immediate jeopardy, which was removed on 2/4/20, when the facility implemented the following plan: Immediate Corrective Action of Resident Affected: Upon notification of event: 2/4/20 RN assessment MD notification Electrician called immediately and onsite to assess outlet in room Electrician to assess all like outlets or receptacle Resident moved to another room Identifying other residents with potential for being affected and interventions to prevent this from occurring in the future. All residents in a private room have the potential to be affected Measures put in place to prevent reoccurrence. System revision. Policy to be reviewed regarding reporting incidents/accidents to DON/NHA Education to be completed immediately on 2/4/20 and prior to clinical staff's next scheduled shift regarding the following: immediate reporting of incidents to DON/NHA, notification to MD/NP and POA if applicable, incident report requirements. Education regarding usage of TELS to communicate needs to Maintenance (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Educate staff on fire safety procedure (fire extinguisher usage (PASS) in event of electrical fire. How facility will monitor system and corrective action: Evaluation of electrical safety to be completed during safety rounds weekly for one month and monthly for three months by Maintenance or designee and report to QAPI. Pain assessment completed every shift for (R7) to monitor for changes in condition All audit results will be reviewed by the facility Quality Assurance Committee to determine if any further staff education or facility policy changes are needed. Any deficiencies will be corrected immediately and reviewed again by the Quality Assurance Committee monthly. All above measures will be subject to review, assessment, and modification. Electrician Invoice # , dated 2/6/20, includes, in part: Emergency Service Call: Need to check over light switch that shocked a resident- please repair . Troubleshoot light for why it would give a resident a shock . Found damage to HOT wire causing box and cover plate to transfer electricity which could cause a shock to someone when touched. Made repairs and tested and have it working properly. Needs . to inspect all resident rooms with lights that are on pull chains for potential problems . (Total of 16 units mentioned in report) - 12 units: no damage to wires and/or device . working properly - 1 unit: resident was too ill to have electrician enter unit - 1 unit: replaced wire nut on the ground wire - 1 unit: replaced pull string - 1 unit: (R7's room) found in this unit the device had gone bad. Replaced with a new device that was supplied by others and tested . Found no further issues with wiring.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility did not prepare, distribute, and serve food in accordance with professional standards for food service safety, which has the potential to affect 69 of 70 residents residing in the facility. Hair restraints were not being used effectively in food preparation areas. Handwashing was not performed according to policy or standard of practice. This is evidenced by: The facility policy titled Food Safety Requirements Guideline, dated 11/28/17, states, in part: .The food service workers, cooks, dietary aides, dishwashers, food prep aides, or any person(s) who are in the kitchen working with any type of food, are responsible for to adhere to the food safety requirements. The facility policy titled Hand Hygiene Guideline, dated 11/28/17, states, in part: Hand hygiene continues to be the primary means of preventing the transmission of infection. It indicates that antimicrobial gel cannot be used in place of proper hand washing techniques in a food service setting and Staff must perform hand hygiene even if gloves are utilized. The facility did not have a policy that addressed hair nets or beard restraints in the kitchen or food preparation areas. On 2/4/20 at 11:47 AM, Surveyor observed Maintenance E in the kitchen and food prep area without a hair restraint. On 2/4/20 at 11:57 AM, Surveyor observed 2 cooks preparing meals without proper hair restraints. Cook C had a large amount of hair on his head, with several strands of exposed hair dangling out of the back of the hair restraint. Cook C also had visible dark facial hair on chin and upper lip, a goatee type growth and longer than stubble that was not covered. At this time, Cook C was plating food at the steam table for residents' lunch. Cook D had a large amount of hair on his head and had braids pulled back into a hair-tie which were not covered by a hair restraint. Cook D had a significant amount of facial hair in a full beard growth which was not covered by a hair restraint. At this time, Cook D was preparing grilled cheese and grilling burgers. While observing plating of food, Surveyor witnessed Cook C remove gloves and discard them, he then grabbed a new pair of gloves, with a bare hand, touched the counter behind the serving area, put on one glove, walked through the kitchen, touched a door with his bare hand, and returned to the steam table, where he finished putting on the second glove and then continued to prepare lunch trays. No handwashing was performed in between this glove change. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/4/20 at 2:05 PM, Surveyor requested kitchen related handwashing and hair restraint policies from NHA A (Nursing Home Administrator). NHA A stated she was not sure if they had one specific to the kitchen, but the facility would follow best practice or standard of practice for each. NHA A indicated that hand washing should be done with any glove change and that hair restraints should be used for any exposed hair by any individual who enters the kitchen. On 2/4/20 at 2:16 PM, Surveyor spoke to Cook D regarding hair restraints who stated, It should all be covered. Surveyor inquired about beard nets and Cook D indicated the facility was out of them right now and was unsure how long they hadn't had them. Cook D also stated it was expected that gloves are changed and handwashing performed after any time you touch something. On 2/4/20 at 2:21 PM, Surveyor observed Cook C unloading boxed food items into standing appliances in the back of the kitchen with no hair restraints on hair or face. Cook C indicated beard nets were available and showed Surveyor where they were located, on a shelf in a storage room. Surveyor asked when hair restraints were to be worn, and he stated, Any time in the kitchen. When asked if he should have hair restraints on at this time, Cook C said, Yes, but I apologize, I just came back from break. Surveyor discussed observation of glove change without handwashing during lunch with Cook C who stated, I was in a hurry, but I try to wash my hands all the time. Cook C agreed hands should be washed in between glove changes.