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	01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Middleton Village (the)	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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not immediately notify and consult with the resident's physician when a significant change in the resident's physical status occurred for 3 of 5 residents reviewed (R1, R5 and R12) of a total sample of 13 residents. In [DATE] the facility was in the midst of a COVID-19 outbreak. R1 experienced a Change in Condition on [DATE] at 6:42 PM when R1's temperature was 99.2 degrees F (Fahrenheit), two degrees above his baseline temperature. R1 complained of being chilled, and staff turned his thermostat to 85 degrees. On [DATE] at 11:00 PM R1 complained of SOB (shortness of breath) and abdominal pain. RN C did not notify and consult with the Physician. Subsequently, on [DATE] at 2:14 AM, R1 called 911 due to shortness of breath. R1 was transported to the ED (Emergency Department) via EMS (Emergency Medical Services). R1 was diagnosed at the ED with COVID-19+, fever, dyspnea, and pneumonia. R1 was admitted to the hospital, where he remained until dying from COVID-related complications on [DATE]. On [DATE], R5 presented with a significant change in altered mental status, reportedly was gurgling all shift, and was requiring oxygen at 4.5 liters/minute. The facility failed to immediately complete a full nursing assessment of R5's condition, or consult with a physician, which delayed in R5 receiving needed emergency medical services. The facility's failure to immediately notify the physician for R1 and R5's significant change of condition created a finding of IJ (Immediate Jeopardy) beginning on [DATE]. On [DATE] at 11:52 AM, NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the IJ. The IJ was removed on [DATE]; however, the deficient practice continues at a scope and severity of a G (actual harm/isolated) as the facility continues to implement its action plan and as evidenced by the following: On [DATE] at 1:00 PM, R12 presented with a significant change in level of consciousness which consisted of R12 having a blank stare and non-responsive to commands. The physcian was not notified. R12 had another episode three days later. R12's weight log documents he was 172 pounds when he was admitted on [DATE] and on [DATE], his weight was documented at 151.2. The facility did not immediately consult with R12's physician regarding this significant change. R12 was admitted to the hospital with [CONDITION(S)] and pneumonia. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Evidenced by: AMDA (American Medical Directors Association) definition of Acute Change of Condition (ACOC): An ACOC 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 complication or death. AMDA (American Medical Directors Association) Protocols for Physician Notification includes, in part: Condition: Temperature - A range of 98.2 degrees F (Fahrenheit) (36.8 degrees Celsius) oral temperature is considered normal. A patient's normal temperature will vary by up to 0.9 degrees Fahrenheit (0.5 degrees Celsius) daily. As quickly as possible after admission, try to establish the patient's normal temperature range. A sudden or rapid change from normal temperature may suggest an ACOC. One temperature reading above 100 degrees Fahrenheit, two readings above 99 degrees Fahrenheit or an increase of 2 degrees above the upper end of the patient's normal range may indicate an ACOC. The facility was unable to provide a policy and procedure for ACOC. Example 1 On [DATE] R1 was admitted to the facility with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R1's Admission MDS (Minimum Data Set) demonstrates his BIMS (Brief Interview for Mental Status) is 14, indicating he is cognitively intact, and requires extensive assistance of two for transferring and toileting. R1 is incontinent of bowel and bladder. R1 is his own person. On [DATE] at 6:42 PM, RN C documented R1's vitals: Temperature: 99.2 (!) (! indicates warning), Respirations: 20, Oxygen Saturation: 94% RA (room air) Blood Pressure: ,d+[DATE], and Pulse: 71. It is important to note that R1's temperature was 99.2 degrees F (Fahrenheit), two degrees above his baseline temperature. R1 also complained of being chilled, and staff turned his thermostat to 85 degrees. On [DATE] at 11:00 PM, R1 complained of shortness of breath for 5 hours, vomiting, and abdominal pain. RN C did not complete a full nursing assessment, including respiratory assessments, abdominal assessments, obtain vital signs, and notify and consult with the Physician. Subsequently, on [DATE] at 2:14 AM, R1 called 911 from his personal phone due to shortness of breath. R1 was transported to the ED (Emergency Department) via EMS (Emergency Medical Services). R1 was diagnosed at the emergency room with COVID-19+, fever, dyspnea, and pneumonia. R1 was admitted to the hospital, where he remained until dying from COVID-related complications on [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:14 AM, the EMS report indicates PSAP (Pubic-Safety Answering Point) R1's call to 911 is received. EMS arrived at the scene at 2:25 AM. Complaint Reported: Breathing problem. The Resident Care Report Narrative reads as follows: EMS was called by a male with shortness of breath. Upon location to this nursing facility EMS is met at the nursing station by two staff members (based on written staff statements this is RN C and LPN H (Licensed Practical Nurse.) The nurse states that our pt (patient) was taken by a different ambulance and we are no longer needed. EMS crew questioned this statement and asked the nurse to make sure and check the room we were dispatched to. The nurse went down to the room and came out and states that The pt (patient) is just mad that I didn't go in there right when he called. The nurse again states that EMS is not needed and we can leave. EMS crew told the nurse that we need to make contact with the pt. The pt is a [AGE] year old male that is found sitting upright on the end of his bed. The pt is naked with a dirty Depends around his knees. The nurse was also in the room with us was very short and rude to the pt when she was speaking to him. The pt asked the nurse to leave the room as she wasn't there to help anything. The pt states that he has been short of breath for ,d+[DATE] hours and when he presses the call light for help the nurse won't come quickly or offer any help. The pt states he has had the chills as well all day and the nurse gave him a warm blanket and turned the thermostat up to 85 degrees which we notice that is still at 85 degrees at this time. Pt had to use his personal cell phone to call 911 as he thought the nursing staff wasn't doing anything for him. The pt requests transport to the hospital. The pt is given a new Depend and placed on the cot. The pt is taken to the ambulance and transport is started to the hospital (at [DATE] at 2:50 AM). The pt's vitals are taken and monitored. The pt has a temperature of 98.4 orally. The pt states he has asthma but this breathing issue feels different. The pt continued to talk about that nurse at the facility and how he isn't treated equally and he feels like she is very mean to him. A radio report is called to the hospital with no further questions or comments given in return. Transport is done without incident and pt care is turned over to hospital staff in room [ROOM NUMBER]. The emergency room (ER) nurse was informed of the situation and she said she would follow up with the facility. On [DATE] at 2:55 AM, RN C documented the following NN (Nurses Notes) in R1's medical record: Res called 911 from room. When EMS (Emergency Medical Services) showed up he told writer he called 911 because he had been waiting for a Certified Nursing Assistant (CNA) for 5 hours. When EMS interviewed him he said he was SOB (short of breath) x 5 hrs (hours) and has been throwing up. Res c/o (complained of) sob (shortness of breath) around 2300 (11:00 PM) and was offered his inhaler but declined saying he didn't need it because he was sob because his belly hurt. Res did not appear to be in any distress. Writer checked on res 15 minutes later and he was sleeping. Res did not appear in any respiratory distress when EMS was here. He was anxious and swung at writer and began swearing at writer when writer informed EMS that he declined inhaler and was sleeping. EMS took res to hospital since they were already here. On [DATE] at 3:29 AM, emergency room Notes, includes, in part: Patient feeling short of breath worsening over the past day. Subjective Fever, chills, cough. Coughing so hard that he felt like he was choking earlier tonight. Apparently, nurse at the nursing home did not help him, so he himself called 911. Patient states there is COVID at the nursing home but not in his wing. Vitals in ER: Blood Pressure ,d+[DATE], Pulse 71, Temp 101.0 (!), Respirations 16, Oxygen Saturation 96%. Note (!) indicates an alert for a reading that is out of normal range and requires further follow up. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assessment Febrile, temp 101 Pulmonary: Crackles in the bases. Pulse ox okay. Chest x-ray: Similar appearance of patchy opacities at the left lung base, possibly representing atelectasis through superimposed infectious process is not excluded. On [DATE] at 5:22 AM, emergency room (ER) Notes, includes, in part: 71 yo (year old) male h/o (history of) afib with pacer (pacemaker), DM (diabetes mellitus), [CONDITION(S)] (hypertension), CHF (congestive heart failure), asthma, multiple CVA's (strokes) - approximately 8. Came from SNF (skilled nursing facility). +COVID going around at his SNF. He had COVID testing done last week which was negative. C/o (complained of) terrible sore throat, cough, sob, fever, chills, and rigors which began Sat AM. He asked his nurse at the SNF to call EMS, but he states she refused, and yelled at him, and told him he was fine. So he called EMS himself. He has also had some mild rhinorrhea and nasal congestion .COVID 19 came back + (positive). Will start [MEDICATION(S)] 6mg intravenous (IV) daily. Will continue antibiotic for possible superimposed bacterial pneumonia, as procalcitonin is elevated, and pneumonia is unilateral. ED work-up remarkable for electrocardiogram (EKG) showing ventricular paced rhythm, normal CBC, chemistry reflects acute on chronic [CONDITION(S)] with creatinine 2.3 which is a little worse than his baseline, troponin negative. BNP, procalcitonin, D-dimer all elevated. Urinalysis negative. Chest x-ray read as patchy opacities left lung base possibly infectious process. Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] Disposition: Admit On [DATE] at 4:23 AM, R1's x-ray report was signed electronically, indicates: Similar appearance of patchy opacities at the left lung base, possibly representing atelectasis though superimposed infectious process is not excluded. Assessment Plan: CXR (chest x-ray) shows LLL (left lower lobe) infiltrate. COVID-19 test came back positive. Will start [MEDICATION(S)] 6mg via IV daily Will continue antibiotics for possible superimposed bacterial pneumonia, as procalcitonin is elevated, and pneumonia is unilateral. R1's ED Physician ordered the following IV (intravenous antibiotics): [MEDICATION(S)] HCL ([MEDICATION(S)]) 750 mg in [MEDICATION(S)] 0.9% 250 ml IVPB 750 mg. Intravenous 250 ml/hr, every 12 hours and [MEDICATION(S)]-tazobactam ([MEDICATION(S)]) 4.5g syringe 4.5 g intravenous, every 8 hours. R1 was admitted to the hospital, where he remained until dying from COVID-related complications on [DATE]. R1's Death Certificate indicates R1's immediate cause of death was acute hypoxemic respiratory failure due to COVID-19. On [DATE] while investigating a complaint filed by the EMT, the former NHA interviewed R1 via phone. R1 reported he told the nurse (RN C) that he couldn't breathe, and she didn't believe him. R1 said that he got tired of arguing with her, so he called 911 himself. R1 states when he told the nurse he didn't feel well and felt he had a fever, she responded that she took his temperature 5 hours ago and he didn't have a fever. R1 states that the nurse also yelled at him for calling 911 and told him he was not allowed to do that. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 states when the paramedics arrived, the nurse was also arguing with them and stating that R1 did not have a fever. R1 states when the paramedics took his temperature, he did have a fever and they took him to the hospital. On [DATE] at 2:30 PM, DON B interviewed RN C and documented an Interview/Statement Record and document a hand written statement on a NN. It is important to note, this information is not part of R1's medical record. The hand written notes read as follows: Res put on call light around 11:00 PM. Writer went to check on him. He c/o (complained of) SOB. He was offered his inhaler but declined stating he was SOB because his belly hurt. Res lips and finger nails were pink. Face was flushed due to being upset. A&Ox3 (alert to person, place and time). neurological faculties WNL (within normal limits) for res. LS (lung sounds) clear to auscultation. (Note, this is inconsistent with the lung assessment at the ED) Breathing steady and unlabored at 20. O2 (oxygen saturation) 96% RA (room air). Bowel sounds present. Belly non-tender. Soft and round belly. Res HOB (head of bed) was ,d+[DATE] degrees. Res complained of emesis 5 min (minutes) before but no signs of emesis found. Res said emesis was in trash. Writer reassured res that lung sounds and belly are ok and his breathing appears normal. Informed him writer would be back in 15 min to check on him. At 11:20 PM res was sleeping. Appeared to be sleeping until 2:30 AM when EMS showed up. When nurse checked on res he said he called 911 because he had been waiting for the CNA for 5 hrs (hours). When paramedics interviewed him he said he had been SOB x 5 hrs and vomiting. No signs of emesis. Res face was flushed from being agitated. Fingers and lips pink. Resp (respirations) regular even and unlabored at 20. When writer informed res that writer had been in there at 11:00 PM and offered inhaler but he declined and he has appeared to be sleeping since 11:20 PM he took a swing in writer's general direction and started swearing. Writer stepped out in hall with one EMS and explained situation and res background. EMS decided to take res to ER because they were here. DON updated. On [DATE] at 2:10 PM, Surveyor spoke with RN C. RN C stated R1 complained of SOB on [DATE] at 11:00 PM. RN C stated she offered R1 his inhaler, completed an assessment, listened to his lungs, and checked his oxygen saturation which was around 90%. RN C stated she told R1 she would be back in ,d+[DATE] minutes and when she returned he was sleeping. RN C stated she didn't hear another peep until the ambulance showed up. RN C stated he told me he called 911 because he didn't have a CNA. Surveyor asked RN C did you notice the temperature you documented in R1's medical record at 6:42 PM alerted as a warning? RN C stated, I was unaware it came up as a warning. Surveyor asked RN C when does a temperature alert as a warning? RN C stated temperatures alert with a warning when it is below 97.0 or above 100.0 degrees. Note, R1's temperature alerted as it is 2 degrees above his baseline temperature. Did you contact R1's physician? RN C stated, No. Surveyor asked RN C, did you take R1's vitals at or after 11:00 PM when R1 was complaining of SOB? RN C stated, Don't ask me what those vitals were I cannot recall! Surveyor asked RN C did you document the vitals? RN C stated, I did not. Surveyor asked should you have documented R1's vitals? RN C stated, I should have. Surveyor asked RN C did you contact R1's NP (Nurse Practitioner) or Physician? I called the NP and left a message after R1 went to the hospital. Surveyor asked RN C did you document this? RN C stated I think so. Surveyor asked RN C when you notify an NP or Physician where do you document the notification? RN C stated, in the Nurses Notes. It is important to note there is no evidence that RN C notified the NP or Physician before R1 called 911 himself due to SOB. RN C stated the she was frustrated by the whole situation and R1 was very rude to her. RN C stated she was tired from being on a long shift (2nd and 3rd shift). RN C stated if a resident is complaining of SOB, I would call the Physician to see if I could get a nebulizer or inhaler ordered or send the resident to the ED. Surveyor asked RN C how soon would you do that if a resident is complaining of SOB? RN C stated, Almost immediately, depending on how short of breath they were. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 4:15 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B if a resident states they are SOB what do you expect staff to do? DON B stated she expects staff to assess the resident's respiratory status, see if they can stabilize the resident, check if there is an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Surveyor asked DON B, what vitals or assessments did RN C document for R1 from ,d+[DATE] after 6:42 PM - [DATE]? DON B stated, I don't believe she documented anything. DON B added, I would expect her to assess the resident, take vital signs, check if the resident has PRN (as needed) medication available for respiratory management, assess skin turgor, and respiratory lung sounds. If a nurse is unable to stabilize a resident he/she should call 911, follow up with the resident's Physician and family. Surveyor asked DON B did RN C document her actions on [DATE] and [DATE] related to R1? DON B stated, I don't think she documented it. DON B added if a resident is in acute distress I would expect the nurse to institute care right away - immediately. Surveyor asked DON B did you notice that the ED's respiratory assessment documents crackles in the bases of R1's lungs and does not concur with RN C's assessment that she documented as part of your investigation. DON B stated, yes, Hence the reason why I educated on SBAR, cephalocaudal (head to toe) assessment, PCC (PointClick Care) SBAR. Surveyor stated on [DATE] at 6:42 PM, RN C documented R1's vitals. R1's temp is documented as 99.2 (Warning high of 99.0 exceeded!) degrees F. Surveyor asked DON B what would you have expected RN C to do? DON B stated, she would have expected RN C to check for PRN (as needed) order for Tylenol, notify R1's Physician and monitor accordingly. Surveyor asked DON B do you feel RN C and/or other facility staff monitored accordingly? DON B stated, Based on what I told you, no. Example 2 R5 was admitted to the facility [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R5's MDS (Minimum Data Set) dated [DATE] documented R5 was cognitively impaired with a BIMS (Brief Interview for Mental Status) of 6 and required extensive assistance with mobility, transfers, hygiene and toileting. R5's Care Plan documents behavior approaches and personal care assistance. R5's [DATE] Progress/Nursing notes document: -2:42 PM-critical INR (international normalized ratio) (blood test for blood thinning medication) 9.4 result received-spoke with physician at anti-coagulant clinic-physician stated to hold [MEDICATION(S)] (blood thinning medication) until [DATE] and redraw blood work on [DATE]. Physician stated not to give [MEDICATION(S)] until labs have been reported to the clinic. It is important to note that the nurse documenting the [MEDICATION(S)] order did not document if she told the physician about a change of condition for R5, who had been lethargic and gurgling all shift per a nurse's note at 10:47 PM. There is no evidence that staff told the physician that R5 was requiring 4.5 liters of oxygen. -10:46 PM -call received from NP (Nurse Practitioner) with orders for fluid goal two liters per day, night shift to total daily fluid intake and blood work [DATE]. There is no evidence that nursing told the NP that R5 had been lethargic and gurgling all shift per a nurse's note at 10:47 PM. There is no evidence that staff told the NP that R5 was requiring 4.5 liters of oxygen. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to complete a full nursing assessment and notify and consult with the Physician as R1 and R5's conditions changed prevented staff from getting a comprehensive picture of R1and R5's clinical conditions and, thus, prevented them from taking appropriate follow-up action, such as prompt consultation with the physician, with complete information about the resident's condition. This failure created a situation of Immediate Jeopardy, which was removed on [DATE] when the facility implemented the following action plan. The 2 identified residents, R1 and R5 no longer reside at the facility. On [DATE], Licensed Nurses and Certified Nursing Assistants were educated on the following: 1. Change in Condition 2. Nursing Assessments 3. Physicians' Notification of Condition Changes (of Residents) 4. Proper Documentation and Timely Follow-up of Changes in Condition. 5. Notification of Resident and/or Responsible Party of Changes in Condition 6. POC Documentation for CNAs CarePlan and Kardex Review. 7. How to Use a Stop-and-Watch Tool. Education to be continued with all Licensed Nurses and Certified Nursing Assistants prior to start of their shifts. In Summary: On [DATE], a full house 'sweep' was completed per facility rounds by licensed nurses to determine if there were any residents who presented with evidence of any change of condition, that would require implementation of resident assessments, change of condition notification to physician/provider, resident and/or resident's responsible party, and requiring documentation of immediate follow-up. On [DATE], there were no residents noted to have a change in condition requiring these specific parameters indicated. On [DATE], Stop-and-Watch tools have been made readily accessible for Certified Nursing Assistants and Licensed Nursing Staffs' access. [DATE] Licensed Nurses and Certified Nursing Staff received education on the proper use of the Stop-and-Watch Tools. All Nursing Staff and CNAs will be educated on the use of Stop-and-Watch Tools and its use prior to their shift worked. On [DATE] Certified Nursing Assistants were provided education on the following: Documenting in POC, Accessing the Resident's CarePlan and Kardex review, and (notifying a licensed nurse when the Kardex Needs Revised/Updated). All Certified Nursing Assistants will receive education regarding this prior to starting their shift until all CNAs receive the education prior to their shift worked. On [DATE], a (24) Hour PointClickCare report was extrapolated via the facility's computer system and reviewed. Contents of nursing documentation of all resident's statuses was reviewed to recognize/identify any areas of concern requiring immediate follow-up, any concerns requiring implementation of a resident assessment, any change of condition requiring immediate follow-up reporting/notifying physician and/or provider, resident and/or responsible party of changes in condition. On [DATE], no findings were observed. On [DATE], the 24 Hour Report Sheet was reviewed to recognize any areas of concern requiring immediate follow-up, any concerns requiring implementation of a resident assessment, any change of condition requiring immediate follow-up reporting/notifying physician and/or provider or resident and/or responsible party of changes in condition. No areas of concern related to changes in condition of residents were observed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Middleton Village (the)	6201 Elmwood Ave Middleton, WI 53562

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], a medical record review was completed on all residents in the facility per (48) Hour Look-back period under resident alerts in charting. Specific charting data that flag sections in PointClickCare System, which is documented by Licensed Nurses. This section of resident alerts in the facility's computer system was reviewed (on all residents) to determine any areas of concern requiring immediate follow-up, any concerns requiring implementation of a resident assessment, any change of condition requiring immediate follow-up reporting/notifying physician and/or provider or resident and/or responsible party of changes in condition. No areas of concern related to changes in condition of residents were observed. On [DATE], resident Change-of-Condition binders have been placed at each nurse's station/cart. The facility's Licensed Nurses and Certified Nursing Assistant Staff were educated on the placement of Change-of-Condition Binders. The policy on Notification of Changes (in Condition) Guidelines and STOP-and-WATCH Tools were placed in those specific binders for Licensed Nurses and Certified Nursing Assistants staff's use and ready access. On [DATE] Computer inputted Vital Signs, Blood Glucose Report were audited/completed on all resident who had documented vitals and blood sugar readings to determine any issues identified to determine any areas of concern requiring immediate follow-up, any concerns requiring implementation of a resident assessment, any change of condition requiring immediate follow-up reporting/notifying physician and/or provider or resident and/or responsible party of changes in condition. No areas of concern related to changes in condition of residents were observed. On [DATE], all physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . No areas of concern related to changes in condition of residents were observed. On [DATE] Audits on the following: 1. Change in Condition 2. Nursing Assessments 3. Physicians' Notification of Condition Changes (of Residents) 4. Proper Documentation and Timely Follow-up of Changes in Condition. 5. Notification of Resident and/or Responsible Party of Changes in Condition were completed to determine any issues requiring any areas of concern requiring immediate follow-up, any concerns requiring implementation of a resident assessment, any change of condition requiring immediate follow-up reporting/notifying physician and/or provider or resident and/or responsible party of changes in condition. No areas of concern related to changes in condition of residents were observed. Audits will continue for compliance monitoring for the following summarized occurrences: (10) residents daily for (1) month, then (3) residents weekly for (2) weeks, then (3) residents (2) times monthly for (1) month, then (3) residents monthly for(1) month. Monthly Random audits will be instituted thereafter. Results of audits to be brought to Quality Assurance/Performance Improvement (QAPI) for review to determine results of specified audits, thus to validate substantial compliance. Licensed Nurses will be educated by Nurse Manager/Designee on how to complete a full head-to-toe assessment. Return Demonstrations by Licensed Nursing Staff (monitored by Nurse Manager/Designee) to validate competency will be performed. Certified Nursing Assistants will be educated by Nurse Manager/Designee on how to properly document in POC and how to appropriately report changes in condition (of residents) to the Licensed Nurses. Certified Nursing Assistants will be evaluated via post-test to determine competency. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross Reference F684 J The deficient practice continues at a scope/severity of G (actual harm/isolated) as evidenced by the following example: Example 3 R12 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R12's MDS admission (Minimum Data Set) indicates mild cognitive impairment, set up with food but independent in eating, extensive assistance requiring [TRUNCATED]

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 3 of 5 residents reviewed (R1, R5 and R12) of a total sample of 13 residents. The facility failed to do the following: 1. R1 is African-American man, has asthma, CHF ([CONDITION(S)]), a pacemaker, and resides in a facility with an active COVID-19 outbreak. R1 experienced a change in condition on [DATE] at 6:42 PM when R1's temperature was 99.2 degrees F (Fahrenheit), two degrees above his baseline temperature. R1 complained of being chilled, and staff turned his thermostat to 85 degrees. At 11:00 PM R1 complained of SOB (Shortness of Breath) and abdominal pain. RN C did not complete a full nursing assessment, including respiratory assessments, abdominal assessments, obtain vital signs, and notify the Physician. Subsequently, on [DATE] at 2:14 AM, R1 called 911 due to shortness of breath. R1 was transported to the ED (Emergency Department) via EMS (Emergency Medical Services). R1 was diagnosed at the ED with COVID-19+, fever, dyspnea, and pneumonia. R1 was admitted to the hospital, where he remained until dying from COVID-related complications on [DATE]. The facility did not implement isolation precautions for R1 when his temperature alerted as a warning on [DATE] at 6:42 PM and he was experiencing chills. 2. On [DATE], R5 presented with a significant change in altered mental status. Staff reported the resident was lethargic and gurgling. He required 4.5 liters of oxygen. The facility failed to immediately complete a full nursing assessment of R5's condition, or consult with a physician, which delayed in R5 receiving needed emergency medical services. R5 died at the facility before paramedics arrived. The facility's failure to assess R1 and R5 when they were experiencing significant changes in condition created a finding of IJ (Immediate Jeopardy) beginning on [DATE]. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the IJ on [DATE] at 11:52 AM. The IJ was removed on [DATE]; however, the deficient practice continues at a scope and severity of a G (actual harm/isolated) as the facility continues to implement its action plan and as evidenced by: On [DATE] at 1:00 PM, R12 presented with a significant change in level of consciousness which consisted of R12 having a blank stare and non-responsive to commands. There is no documented assessment of the resident in the record and no evidence staff notified the physician. He had another episode three days later. R12's weight log documents he was 172 pounds when he was admitted on [DATE] and on [DATE], his weight was documented at 151.2. The facility did not reweigh R12 to determine if this was an accurate weight and did not inform the physician. R12 was admitted to the hospital with [CONDITION(S)] and pneumonia. Evidenced by: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to Chapter N6 of the Wisconsin Nurse Practice Act, An RN (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment: Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient, which includes goals and priorities derived from the nursing diagnosis . Example 1 On [DATE] R1 was admitted to the facility with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R1's Admission MDS (Minimum Data Set) demonstrates his BIMS (Brief Interview for Mental Status is 14, indicating he is cognitively intact, and requires extensive assistance of two for transferring and toileting. R1 is incontinent of bowel and bladder. R1 is his own person. R1 is a DNR (do not resuscitate if respirations or heartbeat cease). R1's CNA Care Card, dated [DATE], indicates the following: Bed Mobility: R1 requires extensive assistance by 1 staff to turn and reposition in bed. Toilet Use: R1 requires extensive assistance by 1 staff for toileting. Hygiene: R1 requires limited assistance (x1) (1 assist) staff with personal hygiene and oral care. Transfers: R1 requires extensive assistance by 1 staff to move between surfaces. Dressing: R1 requires extensive assistance by 1 staff to dress. R1's comprehensive Care Plan, dated [DATE], includes the following focus areas: Focus: R1 has (potential) Respiratory Infection r/t COVID-19, dated [DATE]. Goal: R1 will be free from s/sx of infection by review date. Interventions: Isolation measure will be implemented in accordance with the CDC requirements. Monitor for symptoms to condition change and report to provider: (Changes in vital signs, changes in respiratory status such as increased dyspnea, hemoptysis, decreased o2-oxygen sats, tachypnea). R1 must wear a mask if there is a need to exit the room. R1 should don (put on) a mask/cover mouth, if able, when staff are present in the room. Focus: R1 has a defibrillator r/t hx (history of) cardiac issues. Goal: R1 will remain free from s/sx (signs and symptoms) of pacemaker malfunction or failure through the review date. Interventions: Monitor/document/report PRN (as needed) any s/sx of altered cardiac output or pacemaker malfunction: dizziness, [CONDITION(S)], difficulty breathing (dyspnea), pulse rate lower than programmed rate, lower than baseline b/p (blood pressure). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:42 PM, RN C documented R1's vitals: Temperature: 99.2 (!) (! indicates warning), Respirations: 20, Oxygen Saturation: 94% RA (room air) Blood Pressure: ,d+[DATE], and Pulse: 71. It is important to note that R1's temperature was 99.2 degrees F (Fahrenheit), two degrees above his baseline temperature. R1 also complained of being chilled, and staff turned his thermostat to 85 degrees. On [DATE] at 11:00 PM, R1 complained of shortness of breath for 5 hours, vomiting, and abdominal pain. RN C did not complete a full nursing assessment, including respiratory assessments, abdominal assessments, and notify the Physician. Of note, the facility was in the midst of a COVID-19 outbreak ([DATE] - [DATE]) at this time. There is no evidence that R1 was put on contact and droplet isolation precautions upon symptom onset. On [DATE] at 2:14 AM, R1 called 911 from his personal phone. On [DATE] at 2:14 AM, the EMS (Emergency Medical Services) report indicates PSAP (Pubic-Safety Answering Point) R1's call to 911 is received. EMS arrived at the scene at 2:25 AM. Complaint Reported: Breathing problem. The Resident Care Report Narrative reads as follows: EMS was called by a male with shortness of breath. Upon location to this nursing facility EMS is met at the nursing station by two staff members (based on written staff statements this is RN C and LPN H (Licensed Practical Nurse.) The nurse states that our pt (patient) was taken by a different ambulance and we are no longer needed. EMS crew questioned this statement and asked the nurse to make sure and check the room we were dispatched to. The nurse went down to the room and came out and states that The pt (patient) is just mad that I didn't go in there right when he called. The nurse again states that EMS is not needed and we can leave. EMS crew told the nurse that we need to make contact with the pt. The pt is a [AGE] year old male that is found sitting upright on the end of his bed. The pt is naked with a dirty Depends around his knees. The nurse was also in the room with us was very short and rude to the pt when she was speaking to him. The pt asked the nurse to leave the room as she wasn't there to help anything. The pt states that he has been short of breath for , d+[DATE] hours and when he pressers the call light for help the nurse won't come quickly or offer any help. The pt states he has had the chills as well all day and the nurse gave him a warm blanket and turned the thermostat up to 85 degrees which we notice that is still at 85 degrees at this time. Pt had to use his personal cell phone to call 911 as he thought the nursing staff wasn't doing anything for him. The pt requests transport to the hospital. The pt is given a new Depend and placed on the cot. The pt is taken to the ambulance and transport is started to the hospital (at [DATE] at 2:50 AM). The pts vitals are taken and monitored. The pt has a temperature of 98.4 orally. The pt states he has asthma but this breathing issue feels different. The pt continued to talk about that nurse at the facility and how he isn't treated equally and he feels like she is very mean to him. A radio report is called to the hospital with no further questions or comments given in return. Transport is done without incident and pt care is turned over to hospital staff in room [ROOM NUMBER]. The ER nurse was informed of the situation and she said she would follow up with the facility. On [DATE] at 2:55 AM, RN C documented the following NN (Nurses Notes) in R1's medical record: Res called 911 from room. When EMS (Emergency Medical Services) showed up he told writer that he called 911 because he had been waiting for a CNA for 5 hours. When EMS interviewed him he said he was SOB (short of breath) x 5 hrs (hours) and has been throwing up. Res c/o (complained of) sob (shortness of breath) around 2300 (11:00 PM) and was offered his inhaler but declined saying he didn't need it because he was sob because his belly hurt. Res did not appear to be in any distress. Writer checked on res 15 minutes later and he was sleeping. Res did not appear in any respiratory distress when EMS was here. He was anxious and swung at writer and began swearing at writer when writer informed EMS that he declined inhaler and was sleeping. EMS took res to hospital since they were already here. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:29 AM, emergency room (ER) Notes, includes, in part: Patient feeling short of breath worsening over the past day. Subjective Fever, chills, cough. Coughing so hard that he felt like he was choking earlier tonight. Apparently, nurse at the nursing home did not help him, so he himself called 911. Patient states there is COVID at the nursing home but not in his wing. Vitals in ER: Blood Pressure ,d+[DATE], Pulse 71, Temp 101.0 (!), Respirations 16, Oxygen Saturation 96%. Note (!) indicates an alert for a reading that is out of normal range and requires further follow up. Assessment Febrile, temp 101 Pulmonary: Crackles in the bases. Pulse ox okay. Chest x-ray : Similar appearance of patchy opacities at the left lung base, possibly representing atelectasis through superimposed infectious process is not excluded. On [DATE] at 5:22 AM, emergency room (ER) Notes, includes, in part: 71 yo (year old) male h/o (history of) afib with pacer (pacemaker), DM (diabetes mellitus), [CONDITION(S)] (hypertension), CHF ([CONDITION(S)]), asthma, multiple CVA's (strokes) - approximately 8. Came from SNF (Skilled Nursing Facility). +COVID going around at his SNF. He had COVID testing done last week which was negative. C/o (complained of) terrible sore throat, cough, sob, fever, chills, and rigors which began Sat am. He ask his nurse at the SNF to call EMS, but he states she refused, and yelled at him, and told him he was fine. So he called EMS himself. He has also had some mild rhinorrhea and nasal congestion .COVID 19 came back + (positive). Will start [MEDICATION(S)] 6mg IV daily. Will continue antibiotic for possible superimposed bacterial pneumonia, as procalcitonin is elevated, and pneumonia is unilateral. ED work-up remarkable for electrocardiogram (EKG) showing ventricular paced rhythm, normal complete blood count (CBC), chemistry (labs) reflects acute on chronic [CONDITION(S)] with creatinine 2.3 which is a little worse than his baseline, troponin negative. BNP, procalcitonin, D-dimer all elevated. (Lab values) Urinalysis negative. Chest x-ray read as patchy opacities left lung base possibly infectious process. Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] Disposition: Admit On [DATE] at 4:23 AM, R1's x-ray report was signed electronically, indicates: Similar appearance of patchy opacities at the left lung base, possibly representing atelectasis though superimposed infectious process is not excluded. Assessment Plan: CXR (chest x-ray) shows LLL (left lower lobe) infiltrate. COVID-19 test came back positive. Will start [MEDICATION(S)] (steriod) 6mg via intravenous (IV) daily Will continue antibiotics for possible superimposed bacterial pneumonia, as procalcitonin is elevated, and pneumonia is unilateral. R1's ED Physician ordered the following IV (intravenous antibiotics): [MEDICATION(S)] HCL ([MEDICATION(S)]) 750 mg in [MEDICATION(S)] 0.9% 250 ml IVPB 750 mg. Intravenous 250 ml/hr, every 12 hours and [MEDICATION(S)]-tazobactam ([MEDICATION(S)]) 4.5g syringe 4.5 g intravenous, every 8 hours. R1 was admitted to the hospital, where he remained until dying from COVID-related complications on [DATE]. R1's Death Certificate indicates R1's immediate cause of death was acute hypoxemic respiratory failure due to COVID-19. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the former NHA interviewed R1 via phone while she investigated a complaint filed by the EMT. R1 reported he told the nurse (RN C) that he couldn't breathe, and she didn't believe him. R1 said that he got tired of arguing with her, so he called 911 himself. R1 states when he told the nurse he didn't feel well and felt he had a fever, she responded that she took his temperature 5 hours ago and he didn't have a fever. R1 states that the nurse also yelled at him for calling 911 and told him he was not allowed to do that. R1 states when the paramedics arrived, the nurse was also arguing with them and stating that R1 did not have a fever. R1 states when the paramedics took his temperature, he did have a fever and they took him to the hospital. On [DATE] at 2:30 PM, DON B interviewed RN C and documented an Interview/Statement Record and document a hand written statement on a NN. It is important to note, this information is not part of R1's medical record. The hand written notes read as follows: Res put on call light around 11:00 PM. Writer went to check on him. He c/o (complained of) SOB. He was offered his inhaler but declined stating he was SOB because his belly hurt. Res lips and finger nails were pink. Face was flushed due to being upset. A&Ox3 (alert to person, place and time). neurological faculties WNL (within normal limits) for res. LS (lung sounds) clear to auscultation. (Note, this is inconsistent with the lung assessment at the ED) Breathing steady and unlabored at 20. O2 (oxygen saturation) 96% RA (room air). Bowel sounds present. Belly non-tender. Soft and round belly. Res HOB (head of bed) was ,d+[DATE] degrees. Res complained of emesis 5 min (minutes) before but no signs of emesis found. Res said emesis was in trash. Writer reassured res that lung sounds and belly are ok and his breathing appears normal. Informed him writer would be back in 15 min to check on him. At 11:20 PM res was sleeping. Appeared to be sleeping until 2:30 AM when EMS showed up. When res checked on res he said he called 911 because he had been waiting for the CNA for 5 hrs (hours). When paramedics interviewed him she said he had been SOB x 5 hrs and vomiting. No signs of emesis. Res face was flushed from being agitated. Fingers and lips pink. Resp (respirations) regular even and unlabored at 20. When writer informed res that writer had been in there at 11:00 PM and offered inhaler but he declined and he has appeared to be sleeping since 11:20 PM he took a swing in writer's general direction and started swearing. Writer stepped out in hall with one EMS and explained situation and res background. EMS decided to take res to ER because they were here. DON updated. None of the above assessment is documented in the record, and portions of it conflict with findings found at the emergency room . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:10 PM, Surveyor spoke with RN C. RN C stated R1 complained of SOB at on [DATE] at 11:00 PM. RN C stated she offered R1 his inhaler, completed an assessment, listened to his lungs, and checked his oxygen saturation which was around 90%. RN C stated she told R1 she would be back in , d+[DATE] minutes and when she returned he was sleeping. RN C stated she didn't hear another peep until the ambulance showed up. RN C stated he told me he called 911 because he didn't have a CNA. Surveyor asked RN C if she noticed the temperature she had documented in R1's medical record at 6:42 PM alerted as a warning. RN C stated, I was unaware it came up as a warning. Surveyor asked RN C when does a temperature alert as a warning? RN C stated temperatures alert with a warning when it is below 97.0 or above 100.0 degrees. Note, R1's temperature alerted as it is 2 degrees above his baseline temperature. Did you contact R1's physician? RN C stated, No. Surveyor asked RN C, did you take R1's vitals at or after 11:00 PM when R1 was complaining of SOB? RN C stated, Don't ask me what those vitals were I cannot recall! Surveyor asked RN C did you document the vitals? RN C stated, I did not. Surveyor asked should have documented R1's vitals? RN C stated, I should have. Surveyor asked RN C did you contact R1's NP (Nurse Practitioner) or Physician? I called the NP and left a message after R1 went to the hospital. Surveyor asked RN C did you document this? RN C stated I think so. Surveyor asked RN C when you notify an NP or Physician where do you document the notification? RN C stated, in the Nurses Notes. It is important to note there is no evidence that RN C notified the NP or Physician before R1 called 911 himself due to SOB. RN C stated the she was frustrated by the whole situation and R1 was very rude to her. RN C stated she was tired from being on a long shift (2nd and 3rd shift). Surveyor asked RN C what assessments did you complete related to R1's report of SOB? RN C stated she assessed R1's lung sounds, pulse oximeter (oxygen saturation), and checked to see if the resident's breathing is labored. RN C stated R1 said his stomach hurt so I did an abdominal assessment and that came back unremarkable. RN C stated if a resident is complaining of SOB, I would call the Physician to see if I could get a nebulizer or inhaler ordered or send the resident to the ED. Surveyor asked RN C how soon would you do that if a resident is complaining of SOB? RN C stated, Almost immediately, depending on how short of breath they were. It is important to note that the last set of vitals for R1 is on [DATE] at 6:42 PM and there are no assessments documented either. RN C stated, I did a very poor job documenting that night. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 4:15 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B if a resident states they are SOB what do you expect staff to do? DON B stated she expects staff to assess the resident's respiratory status, see if they can stabilize the resident, check if there is an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Surveyor asked DON B, what vitals or assessments did RN C document for R1 from ,d+[DATE] after 6:42 PM - [DATE]? DON B stated, I don't believe she documented anything. DON B added, I would expect her to assess the resident, take vital signs, check if the resident has PRN (as needed) medication available for respiratory management, assess skin turgor, and respiratory lung sounds. If a nurse is unable to stabilize a resident he/she should call 911, follow up with the resident's Physician and family. Surveyor asked DON B did RN C document her actions on [DATE] and [DATE] related to R1? DON B stated, I don't think she documented it. Surveyor asked DON B when was the last time a CNA/Nurse provided care to R1 on ,d+[DATE] or [DATE]? DON B stated CNA J was agency. DON B added she has made multiple attempts to contact the CNA, with no return call, and she has since quit the agency. DON B stated there is no documentation whatsoever from the CNA assigned to work with R1. Surveyor asked DON B did RN C go back and check on R1 after she noted he was sleeping? DON B stated she asked RN C that question. RN C stated she did but there was no proof in R1's medical record. RN C stated to DON B that she asked the CNA to check on R1. RN C could not remember the CNA's name or what she looked like. Surveyor asked DON B what would you have expected RN C to do? DON B stated depending on the scenario and if the resident is stable I would expect her to go back periodically, at least every ,d+[DATE] minutes. DON B added if a resident is in acute distress I would expect the nurse to institute care right away - immediately. Surveyor asked DON B did you notice that the ED's respiratory assessment documents crackles in the bases of R1's lungs and does not concur with RN C's assessment that she documented as part of your investigation. DON B stated, yes, Hence the reason why I educated on SBAR, cephalocaudal (head to toe) assessment, PCC (PointClickCare) SBAR. Surveyor stated on [DATE] at 6:42 PM, RN C documented R1's vitals. R1's temp is documented as 99.2 (Warning high of 99.0 exceeded!) degrees F. Surveyor asked DON B what would you have expected RN C to do? DON B stated, she would have expected RN C to check for PRN (as needed) order for Tylenol, notify R1's Physician and monitor accordingly. Surveyor asked DON B do you feel RN C and/or other facility staff monitored accordingly? DON B stated, Based on what I told you, no. Surveyor asked DON B if R1 should have been put on isolation when experiencing a temperature and chills. DON B stated, yes. Surveyor asked DON B if there is evidence that R1 was put on isolation precautions when experiencing symptoms of COVID. DON B stated, no. The facility failed to assess R1 when he was noted to be experiencing a change in condition, exhibiting a temperature of 2 degrees above his baseline and complained of being chilled. R1 then complained of being short of breath and having abdominal pain. There is no evidence that RN C completed a full nursing assessment, including respiratory assessments, abdominal assessments, and obtained vital signs. There is no evidence that staff quarantined R1 when his temperature was 2 degrees above baseline and he complained of being chilled on [DATE] at 6:42 PM, There is no evidence that staff continued to monitor and assess R1's condition. Example 2 R5 was admitted to the facility [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R5's MDS (Minimum Data Set) dated [DATE] documented R5 was cognitively impaired with a BIMS (Brief Interview for Mental Status) of 6 and required extensive assistance with mobility, transfers, hygiene and toileting. (continued on next page)

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	01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Middleton Village (the)	6201 Elmwood Ave Middleton, WI 53562

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R5's Care Plan documents behavior approaches and personal care assistance. DON investigated the care of R5 on ,d+[DATE] and [DATE]. Per this investigation: LPN D (Licensed Practical Nurse) wrote on [DATE] she took care of this resident for the [DATE] to [DATE] night shift. The resident wanted to stay up and told the nurse to turn sports on please-resident was asleep from 3:00 AM to 6:00 AM. Vital signs were stable during the night ,d+[DATE]/-[DATE]. On [DATE] at 5:30 PM, Surveyor spoke with DON B. DON B said she had completed oral care on R5 that morning ([DATE]) before breakfast. DON B said she had performed oral care because the CNA on R5's assignment said R5 had refused oral care done by her. DON B said R5 was not in respiratory distress or lethargic at that time. In her statement to the DON, LPN E wrote on [DATE] that R5 was under my care for the day shift (on [DATE]). During the shift resident was easily aroused, took meds in applesauce. Resident had been sleeping but was aroused and took most of his meds .resident did not seem to be in any distress or discomfort any time during this shift . R5's [DATE] Progress/Nursing notes document: -2:42 PM-critical INR (international normalized ratio) (blood test for blood thinning medication) 9.4 result received-spoke with physician at anti-coagulant clinic-physician stated to hold [MEDICATION(S)] (blood thinning medication) until [DATE] and redraw blood work on [DATE]. Physician stated not to give [MEDICATION(S)] until labs have been reported to the clinic. Late entry written at 10:47 PM for the afternoon of [DATE] - R5 was on O2 (oxygen) at 4.5 liters at start of shift. He was lethargic and gurgling. CNA (Certified Nurse Assistant) said he had been like this all day and it was reported he was like this last night as well. R5's daughter came for window visit and had many questions about res. condition. Writer reported she would investigate and contact daughter when writer knew more. Vital signs blood pressure (BP) ,d+[DATE] temperature (T) 97.1 heart rate (HR) 85 respirations (R) 22 and oxygen saturation (O2 Sat) (measurement of oxygen in the blood) 68% on 4.5 liters of oxygen per nasal cannula. 911 contacted and EMS dispatched. By the time EMS arrived at 4:20 PM, res. was expired. Res. daughter was updated at 6:30 PM and questions answered as best as possible. Resident physician on call was contacted at 6:45 PM and he pronounced res. expired and released body to funeral home. Voice mail left for NP. Questions answered by staff for [name of police force] police. Body released to funeral home at 9:00 PM. Of note: this nursing note indicates it was documented at 10:47 PM, however the change of condition for R5 occurred prior to 4 PM and R5 expired at 4:20 PM. On [DATE] at 2:10 PM, Surveyor spoke with RN C (Registered Nurse). RN C said she does not recall the CNA that told her the resident was lethargic and gurgling all day. He was lethargic when she came on shift. (There was no documented assessment of R5's lethargy.) When the resident daughter was at the window visit at 3:00 PM, he seemed improved. RN C said the report she received from LPN E was that LPN E did not know the resident. RN C said she thinks she did vital signs-they were stable. RN C said she thinks she called the physician. RN C said she did not document calling the physician, completing an assessment or the vital signs. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:00 PM, Surveyor spoke to R5's (dtr) daughter. R5's dtr. said she had not spoken to R5 in a couple of days, which was usual for them. R5's dtr. said she wanted to do a window visit with R5, so she called the facility and requested a time for a window visit. R5's dtr. said she would arrive between 3:30 and 4:00 PM. R5's dtr. waited 20 minutes after arriving at the facility for R5. She asked a women passing by to check on R5 to see why he had not come to the window yet. The women reported back to R5's dtr. They are having trouble with his oxygen. R5's dtr said she thought this was wrong, because R5 never used oxygen. RN C brought R5 to the window. R5's dtr. said he was non-responsive and breathing heavily and that he had oxygen on. R5's dtr. said to RN C, What is wrong with him? RN C told R5's dtr. He's sleepy. R5's dtr. said to wake him up. RN C touched R5 on the shoulder and spoke to him. R5's dtr. said he did not respond. R5's dtr. told RN C to find out what was wrong with R5 and call her back within an hour. RN C took R5 away from the window. R5's dtr. said RN C called 45 minutes to one hour later to say R5 expired. On [DATE] at 3:15 PM, Surveyor spoke with MD F (Medical Doctor). MD F said he was not aware that the resident had a change of condition. MD F said he was not aware the resident had expired until he received the death certificate to sign. MD F said the cause of death was complications of [CONDITION(S)] (a heart condition). MD F said if he had been contacted that the resident had a high INR and/or a change of condition he would have ordered the resident be sent to the emergency room . R5 presented with a significant change of condition, lethargic and gurgling per R5's nursing note and staff report, however there is no indication RN C completed a nursing assessment and called the physician to report R5's significant change of condition. In fact R5 was brought to a window visit vs. receiving emergency care to sustain life. R5 expired secondary to an acute change of condition and complications of [CONDITION(S)]. Facility failure to assess and monitor R1 and R5 after they experienced significant changes in condition, and failure to intervene as needed based on these assessments created a finding of IJ (Immediate Jeopardy) beginning on [DATE] at 6:42 PM. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the IJ on [DATE] at 11:52 AM. The IJ was removed on [DATE] when the facility implemented the following: The 2 identified residents, R1 and R5 no longer reside at the facility. On [DATE], Licensed Nurses and Certified Nursing Assistants were educated on the following: 1. Change in Condition 2. Nursing Assessments 3. Physicians' Notification of Condition Changes (of Residents) 4. Proper Documentation and Timely Follow-up of Changes in Condition. 5. Notification of Resident and/or Responsible Party of Changes in Condition 6. POC Documentation for CNAs CarePlan and Kardex Review. 7. How to Use a Stop-and-Watch Tool. Education to be continued with all Licensed Nurses and Certified Nursing Assistants prior to start of their shifts. In Summary: On [DATE], a full house 'sweep' was completed per facility rounds by licensed nurses to determine if there were any residents who presented with evidence of any change of condition, that would require implementation of resident assessments, change of condition notification to physician/provider, resident and/or resident's responsible party, and requiring documentation of immediate follow-up. On [DATE], there were no residents noted to have a change in condition requiring these specific parameters indicated. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Stop-and-Watch tools have been made readily accessible for Certified Nursing Assistants and Licensed Nursing Staffs' access. [DATE] Licensed Nurses and Certified Nursing Staff received education on the proper use of the Stop-and-Watch Tools. All Nursing Staff and CNAs will be educated on the use of Stop-and-Watch Tools and it's use prior to their shift worked. On [DATE] Certified Nursing Assistants were provided education on the following: Documenting in POC, Accessing the Resident's CarePlan and Kardex review, and (notifying a licensed nurse when the Kardex Needs Revised/Updated). All Certified Nursing Assistants will receive education regarding this prior to starting their shift until all CNAs receive the education prior to their shift worked. On [DATE], a (24) Hour PointClickCare report was extrapolated via the facility's computer system and reviewed. Contents of nursing documentation of all resident's statuses was reviewed to recognize/identify any areas of concern requiring immediate follow-up, any concerns requiring implementation of a resident assessment, any change of condition requiring immediate follow-up reporting/notifying physician and/or provider, resident and/or responsible party of changes in condition. On [DATE], no findings were observed. On [DATE], the 24 Hour Report Sheet was reviewed to recognize any areas of concern requiring immediate follow-up, any concerns requiring implementation of a resident assessment, any change of condition requiring immediate follow-up reporting/notifying physician and/or provider or resident and/or responsible party of changes in condition. No areas of concern related to changes in condition of residents were observed. On [DATE], a m [TRUNCATED]

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility did not ensure completion of performance review for every nurse aide, at least once every 12 months, for 3 of 5 staff members randomly selected for review. CNA K (Certified Nursing Assistant) did not have a performance evaluation in the past 12 months. CNA L did not have an evaluation in the past 12 months. CNA M did not have an evaluation in the past 12 months. This is evidenced by: Example 1: CNA K has a hire date of 7/7/15; CNA K's yearly performance evaluation should have been completed on or around 7/7/20. Upon request, the facility provided no completed evalution for CNA K to review. Example 2: CNA L has a hire date of 12/12/19; CNA L's 1 year evaluation should have been completed on or around 12/12/20, the facility provided no completed evalution for CNA L to review. Example 3: CNA M has a hire date of 12/12/19; CNA M's yearly evaluation should have been completed on or around 12/12/20, the facility provided no completed evalution for CNA M to review. On 1/27/21 at 5:00 PM, Surveyor interviewed DON B (Director of Nursing) regarding the three CNA 's (CNA K, CNA L, and CNA M) performance evaluations. DON B indicated CNA performance evaluations should be completed at least annually and were not.