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	08/31/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility policy and procedure review, the facility did not implement professional standards of practice to prevent PIs (pressure injuries) from developing, worsening, or to promote healing of PIs. Assessments of PIs were not consistently being completed by an RN (Registered Nurse), for 2 of 3 residents (R1, R2) reviewed for PIs out of a sample of 5 residents. On [DATE] a CNA (Certified Nursing Assistant) discovered a stage 3 PI on R1's coccyx measuring 10.0 cm x 10.0 cm and a stage 3 PI on R1's left heel measuring 8.0 cm x 7.0 cm. The heel PI was malodorous. R1 was hospitalized [DATE] where both PIs were identified as being infected. R1 received four (4) IV (intravenous) antibiotics during his 1 week hospitalization . Staff identified a stage 3 PI on R2's left heel on [DATE] that measured 1.7 x 3.2 x 0.10 cm; the wound bed is documented as 75% Pink or red non-granulating and 25% slough loosely adherent. From ,d+[DATE] - [DATE] the wound bed was documented as 75% non-blanchable [CONDITION(S)] and 25% non-granulated tissue. This PI remained stable and about the same size until [DATE] when there was undermining and 100% slough. The facility did not consult with R1's Physician or NP (Nurse Practitioner) on this date and no change in treatments or in R2's care plan. On [DATE] R2's PI was 3.5 x 5.0 x 0.1 cm and was 90% necrotic and 10% beefy red. There was no consultation with a Physician and no change in treatment. The facility did not assess or measure the PI the following week, and there is no documentation of an assessment or measurement until [DATE]. At that time, the PI was significantly larger, measuring 10.5 x 9.0 x 0.30 cm and remained 90% necrotic. The facility notified NP H (Nurse Practitioner), who ordered [MEDICATION(S)], an antibiotic. The facility did not assess the wound again until [DATE], 13 days later. The PI was 10.0 x 6.0 x 0 and was 100% necrotic. R2 went on hospice on [DATE] and expired on [DATE]. R1 and R2 developed new pressure injuries (PI) that worsened. Staff failed to identify, measure, and assess R1 and R2's wounds weekly, failed to contact a Physician/NP timely, or implement preventative measures timely to prevent R2's PI from deteriorating /worsening. This created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA A (Nursing Home Administrator), DON B (Director of Nursing) and DOCO G (Director of Clinical Operations) of the immediate jeopardy on [DATE] at 3:08 PM. The immediate jeopardy was removed on [DATE] and continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility implements its action plan. As evidenced by (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's policy, Skin Management Guideline, dated [DATE], indicates in part, the following: Purpose: to ensure residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown . Inspection of skin with daily cares and weekly by a licensed nurse. Specified turning and repositioning Pressure, friction, shear reduction A. Turning and Repositioning Observation - For those residents that are immobile, or need assistance with mobility evaluate turning and repositioning needs: Upon admission, Re-admission, with a change of condition and annually II. treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . Review the wound formulary guidance 2. Consult with the Physician/NP and Resident Representative 3. Notify Supervisor/Designee as assigned 4. Notify Dietary for nutritional interventions 5. Notify Therapy Department for seating surface evaluation and possible treatment interventions and other interdisciplinary team members as appropriate. 6. Re-evaluate turning and repositioning interventions 7. Initiate Braden Scale and initiate investigation process if new onset 8. Evaluate interventions per risk factors identified and re-evaluate and modify the plan of care based on root cause analysis for new skin alterations . 9. Update the Care Plan for Skin Integrity and nursing assistant care cards with skin concern, appropriate risk factors, turning intervals and interventions as appropriate. 11. When a pressure ulcer is present, daily wound monitoring should include: An evaluation of the ulcer, if no drainage is present; An evaluation of the status of the dressing, if present; The status of the area surrounding the ulcer (that can be observed without removing the dressing); The presence of the possible complication, such as signs of infections; Whether pain, if present, is being adequately controlled 12. Consult with a Physician/NP, Family and Supervisor/Designee if the ulcer(s) has not shown progress in two weeks. 13. Consult with the Physician/NP if the wound is deteriorating or increases in size. Re-evaluate plan of care as appropriate. Resident Choice - In order for a resident to exercise his or her right to appropriately make informed choices about care and treatment or to refuse treatment, the facility and the resident (or the Resident Representative) will discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The facility will address the resident's concerns and offer relevant alternatives if the resident has refused treatments/interventions. This will be documented in PCC using the Risk versus Benefits to provide an opportunity to make an informed decision . The NPIAP classifies a pressure injuries as follows: Stage 3: Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. Stage 4: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and [MEDICATION(S)] tracts may be associated with Stage 4 pressure ulcers. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Example 1 R1 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R1 has an APOAHC (Activated Power of Attorney for Health Care). Surveyor requested R1's Braden Assessment scores (a measure of pressure injury risk) from DON B. DON B did not provide any documentation. R1's Admission MDS (Minimum Data Set) dated [DATE] indicates R1 is cognitively intact with a BIMS (Brief Interview for Mental Status) of 13 and requires extensive assistance of 2 for bed mobility, and extensive assist of 1 for transferring, walking on and off the unit, dressing and toileting. R1's MDS indicates he is at risk for PI development and he was admitted with no PIs. R1's Quarterly MDS dated [DATE] indicates R1 is cognitively intact with a BIMS of 12 and requires limited assist of 2 for bed mobility and transfers, and extensive assist of 1 for walking on the unit, toileting and extensive assist of 2 for dressing. R1's Visual /Bedside Kardex, dated [DATE], indicates the following for Skin: Ensure that heels are elevated while resident is lying in bed; use foam offloading heel float-if refused use pillows to float heels; Keep HOB (head of bed) at or below 30 degrees. When elevating HOB, [NAME] knees or place pillow under knees; Assess fingers and toes for warmth and color PRN (as needed); avoid positioning the resident on back. Position side to side. Maintain both heels in a floating position using heel floater; Ensure that R1's shoes fit well and do not place pressure on his bunion. R1's comprehensive care plan indicates the following: R1 has the potential for impairment to skin integrity r/t (related to) age related changes to skin, hallux valgus (bunion), incontinence, limited mobility (Date Initiated [DATE]) - Apply barrier cream per facility protocol to help protect skin from excess moisture (Date Initiated [DATE]); Ensure that heels are elevated while resident is lying in bed (Date Initiated [DATE]), use foam offloading heel float - if refused use pillows to float heels; Keep HOB (head of bed) at or below 30 degrees (Date Initiated [DATE]). When elevating HOB, [NAME] knees (this means to place a pillow under the knee/knees so it/they are at an angle or either comfort or to take the pressure of the lower back) or place pillow under knees (Date Initiated [DATE]); Pressure reduction bed mattress (Date Initiated [DATE]); Wheelchair pressure reduction cushion (Date Initiated [DATE]); Educate resident/family/caregivers of causative factors and measure to prevent skin injury (Date Initiated [DATE]); Ensure that R1's shoes fit well and do not place pressure on his bunion (Date Initiated [DATE]) Surveyor requested information from DON B regarding R1's mattress. DON B did not provide the requested information. R1's medical record does not note any pressure injuries until [DATE]. On that date R1's Coccyx Wound Assessment Details Report indicates the following measurements in centimeters (cm): [DATE] - 10.0 cm x 10.0 cm x Unknown *Source: Facility-acquired (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date Identified: [DATE] Identified by: DON B (Director of Nursing) Assessment Information: [DATE] at 8:51 AM *Clinical Stage: 3 Exudate: None Periwound Criteria: [CONDITION(S)] Wound Edge: Separate from base Odor: No Sings of Infection Present: Unable to determine Is patient on antibiotics: No Dressing Present: Yes Dressing Date & Initialed: Yes Undermining: Unknown Tunneling: Unknown R1's Left Heel Wound Assessment Details Report indicates the following: [DATE] - 8.00 cm x 7.00 cm x Unknown Type: Pressure *Source: Facility-acquired Date Identified: [DATE] Identified by: DON B (Director of Nursing) Assessment Information: [DATE] at 8:44 AM *Clinical Stage: 3 Exudate: None Periwound Criteria: [CONDITION(S)] (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound Edge: Separate from base *Odor: Yes Sings of Infection Present: No Is patient on antibiotics: No Dressing Present: Yes Dressing Date & Initialed: Yes Undermining: None Tunneling: None On [DATE] NP H (Nurse Practitioner) documents the following note: SNF (Skilled Nursing Facility) nurse calling to report patient with DTI (Deep Tissue Injury) to left heel and pressure ulcer to coccyx. Did not have measurements or stage of pressure injury, believes coccyx was a stage 2 or 3 probably stage 3. Discussed treatment for [MEDICAL RECORD OR PHYSICIAN ORDER] . Discussed having DON B assess wounds, coccyx likely will apply skin prep to peri wound intact skin and [MEDICATION(S)] to open area; but final plan pending more thorough assessment. Nurse to call NP H back with measurements of both wound and stage of pressure injury to coccyx. NP H also placed call to DON B with update on wound and request further assessment. NP H has not heard back from DON B or floor nurse; message left again for DON B to follow-up. NP H has not received return call from DON B and attempted again to reach without answer. Reiterated NP H has not heard of wound assessments and yesterday was the first time NP H was made aware of any wounds. Per SNF EHR (Electronic Health Record): Stage 3 facility acquired pressure injury to coccyx measuring 10.0 cm x 10.0 cm. No odor or drainage per documentation. (Note, photos of R1's heel and coccyx are included in NP H's note). Plan: Refer to wound care, XR (x-ray) L (left) heel 2 view stat, Start Prosource 30ml (milliliters) daily, CBC no diff (differential) to r/o (rule out) infection, reiterated to staff must keep pressure off heel and coccyx, discussed trying to get air mattress. On [DATE] R1's Radiology Report, signed by the Radiologist at 7:27 PM, indicates the following: Results: Oblique and lateral projections. Markedly suboptimal x-ray beam penetration. Calcaneal enthesophytes noted. No gross acute fracture, osseous lesion or dislocation. Conclusion: No gross acute bony abnormality given the limitations of the study. Repeat as needed. On [DATE], the NP covering for NP H noted the following: NP called the facility and requested a fax number to send radiology report back with signature and orders to continue current wound care; referral already made to hospital Burn and Wound Clinic-refer to telephone encounter [DATE] for further details of referral. R1's Coccyx Wound Assessment Details Report: indicates the following: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]- 10 cm x 10.0 cm x Unknown (Note, based on the facility's photographic documentation, this PI has visibly increased in size from two days prior with more necrotic tissue.) Source: Facility-acquired Date Identified: [DATE] Identified by: DON B (Director of Nursing) Assessment Information: [DATE] at 8:51 AM *Clinical Stage: 3 Exudate: None Periwound Criteria: [CONDITION(S)] Wound Edge: Separate from base Odor: No Sings of Infection Present: Unable to determine Is patient on antibiotics: No Dressing Present: Yes Dressing Date & Initialed: Yes Undermining: Unknown Tunneling: Unknown R1's Left Heel Wound Assessment Details Report indicates the following: [DATE] - 8.00 cm x 7.00 cm x 0.00 Type: Pressure Source: Facility-Acquired Clinical Stage: Unstageable Periwound Criteria: [CONDITION(S)] Wound Edge: Distinct and attached *Odor: Yes (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Sings of Infection Present: No Is patient on antibiotics: No Dressing Present: Yes Dressing Date & Initialed: Yes Undermining: None Tunneling: None General: Tissue Type: Purple Ecchymosis-100% On [DATE] at 6:39 PM, the hospital report indicates R1 arrived to the ED (emergency department). Admission Diagnoses: [MEDICAL RECORD OR PHYSICIAN ORDER] On [DATE], hospital documentation indicates R1's APOAHC (Activated Power of Attorney for Health Care) requests / agrees to: 1. Immediate transition to COMFORT CARE ONLY. -no further surgical debridement -no further IV abx (antibiotics) -no further testing (MRI, bone scan, labs, etc.) 2. DNR (Code Status: Do Not Resuscitate) - COMFORT 3. Liberal use of comfort medications 4. NO [MEDICATION(S)] tube artificial hydration/nutrition 5. Palliative feeds for comfort 6. Discharge to 24 hour facility with hospice - no hospice preference 7. NO rehospitalization Hospice consult ordered. Hospice Eligibility / Certification of a Terminal Illness - Given the patient's [CONDITION(S)], heart failure with reduced ejection fraction, chronic [CONDITION(S)], Parkinsonism, [CONDITION(S)] and [CONDITION(S)] disorders, severe dysphasia, bedbound status, [CONDITION(S)] bacteremia, infected pressure ulcers of the left calcaneus (heel) and sacral areas, and family decision against further aggressive medical intervention, it is my medical judgement that his prognosis, should his diseases progress as expected, is less than 6 months and eligible for hospice services. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's wound cultures at the hospital are as follows: Left Heel: [DATE] Proteus mirabilis, MSSA ([CONDITION(S)]-susceptible staphylococcus aureus) Coccyx: [MEDICATION(S)] gram negative and gram positive rods On [DATE] at 12:22 AM, R1's ED (emergency department) H&P (History and Physical) indicates, in part, the following: .with a history significant for CAD ([CONDITION(S)]), HFrEF (heart failure with reduced ejection fraction), heart flutter on [MEDICATION(S)], [CONDITION(S)] (hypertension), [CONDITION(S)] disorder, [CONDITION(S)] disorder, parkinsonism, tardive dyskinesia, chronic headache, hyperthyroid, polyneuropathy, sleep-disordered breathing, history of substance abuse with alcohol and cocaine with presents with coccygeal wound and fatigue. [CONDITION(S)] likely secondary to coccygeal wound, foul smelling draining wound on coccyx, stage 3 per nursing notes and measuring 10 x 10 cm, dressed in ER. Lactic acid 2.4, procal 0.18, s/p (status post [MEDICAL RECORD OR PHYSICIAN ORDER] . S/p (status post [MEDICAL RECORD OR PHYSICIAN ORDER] . Critical Care Documentation: R1 was critically ill, with a high risk of imminent or life-threatening deterioration in condition; Risk for severe [CONDITION(S)] requiring fluid resuscitation (Circulatory failure) History: Chief Complaint - Lethargy - R1 sent from facility for lethargy, hasn't been eating/drinking or ambulating as normal x2 days. On [DATE], R1's hospital discharge summary indicates the following: 1. Coccyx wound: Stage 3 wound at admission with foul smelling drainage. Wound care followed for dressing of wound. Started on antibiotics [MEDICATION(S)] and [MEDICATION(S)] in the ED. Antibiotics were escalated throughout admission to [MEDICATION(S)] and [MEDICATION(S)] per Infectious Disease. Wound cultures and blood cultures were drawn. Nuclear imaging via tagged white blood cell scan was attempted to assess for [CONDITION(S)], but was ultimately inconclusive. This prompted conversations with family and patient re: comfort care. See below for further detail. 2. Left Heel wound: Similar management as above in terms of antibiotic courses and attempts at imaging to determine [CONDITION(S)]. Decision ultimately made to forego further surgical debridement. 3. Patient and family were engaged with conversations with palliative care towards middle of hospitalization . Decision was made to pursue comfort care and hospice given advanced staging of wounds and other chronic co-morbid conditions. Because of this, [MEDICATION(S)] was discontinued. No further debridement of the wounds is warranted. Escalation, liberally, of pain medication is appropriate . On [DATE] upon re-admission to the facility, R1's Nursing Evaluation indicates R1 has skin impairments: 50. Left Heel and 23. Coccyx. Note, there is no assessment or measurements of R1's PIs upon readmission. R1 declined for Surveyor to observe cares and PI treatments. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:04 PM, Surveyor spoke with NP H (Nurse Practitioner). Surveyor asked NP H when the facility first notified her of R1's PI to his coccyx and left heel. NP H stated the facility notified her on [DATE]. NP H stated she was not available to come to the facility and reviewed the wound documentation and pictures in R1's EHR (electronic health record). NP H stated R1 had a huge unstageable PI to his left heel and coccyx that were both black. Surveyor asked NP H what stage are R1's PI's. NP H stated, stated without seeing the PI's in person, NP H stated, Probably a stage 3. Surveyor asked NP H when you would expect to be notified of a PI (pressure injury). NP H stated, I would expect to be notified immediately when a PI is found. NP H indicated she was never notified when these PI's were a Stage 1 or 2, and they were both Stage 3 when discovered. NP H stated usually PIs are noted on shower days or with cares, however, these PIs were not noted prior to being discovered at a stage 3. NP H stated since the prior WCC (Wound Care Certified) RN (Registered Nurse) left (her last day was [DATE]), I am rarely getting notified of a change in wound. Surveyor asked NP H if R1's PI's to his coccyx and heel were avoidable or unavoidable. NP H stated R1's PI's are avoidable. Surveyor asked NP H were R1's PI's infected. NP H stated, yes, R1's coccyx wound was very foul smelling with a lot of drainage. NP H added, R1 received multiple IV (intravenous) antibiotics while hospitalized for 1 week. Surveyor asked NP H the results of R1's cultures. NP H stated R1's blood culture was positive for streptococcus, R1's left heel culture indicated Proteus Mirabalis and MSSA; R1's coccyx culture indicated [MEDICATION(S)] gram negative and positive rods. NP K stated that on [DATE] the facility transitioned R1's care to their Medical Director. On [DATE] at 10:10 AM, Surveyor spoke with CNA E (Certified Nursing Assistant). Surveyor asked CNA E if R1 refuses care. CNA E stated R1 does not refuse care, however, he will move his feet so they're not floated because he keeps moving. CNA E stated we use Heelz Up and pillows to float R1's feet. On [DATE] at 10:12 AM, Surveyor spoke with CNA J, (Certified Nursing Assistant). CNA J stated she tried to float R1's feet this morning, however, he kept putting his feet down. CNA J stated she told CNA E who in turn told LPN L (Licensed Practical Nurses). Note, there is no documentation or evidence that staff followed up regarding this. Surveyor requested documentation from DON B. DON B did not provide any additional documentation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:25 PM and 3:08 PM, Surveyor spoke with DON B (Director of Nursing) and DOCO G (Director of Clinical Operations). Surveyor asked DON B and DOCO G what standard of practice the facility follows for PIs. DOCO G stated the facility follows the NPIAP (National Pressure Injury Advisory Panel). Surveyor asked DON B when the previous WCC (Wound Care Certified) RN left. DON B indicated she left [DATE]. Surveyor asked DON B who is your wound care nurse. DON B stated she is the wound care nurse. Surveyor stated RN F documented wound care notes. DON B stated she is no longer assigned to wound care. Surveyor asked DON B if RN F is wound care certified. DON B stated, no. Surveyor asked DON B, are you wound care certified. DON B stated, yes. Surveyor asked DON B how often are PIs to be measured. DON B stated, Weekly or with changes. Surveyor asked DON B, when should the Physician/NP be notified of a PI. DON B stated, on discovery, with any changes, if doing a treatment for 2 weeks with no change (improvement), and any decline in the wound. Surveyor asked DON B is there any documentation of R1's PI's at a Stage 1 or 2. DON B stated, no. Surveyor asked DON B do you have any concerns regarding the stage that R1's coccyx and left heel PI's were discovered. DON B stated, Yes. DON B stated, she noted a decline in R1's condition. Surveyor asked DON B what date she noted the decline in R1's condition. DON B stated, It was gradual, it wasn't any specific date. Surveyor asked DON B, what is the root cause of R1's PI to his coccyx and left heel. DON B stated, Lying in bed, refusals to move around. Surveyor asked DON B if R1's refusals are documented. DON B stated she will check. The facility did not provide further information. Surveyor asked DON B did the facility provide risks and benefits to R1 and his APOAHC related to his refusals to reposition. DON B stated, I don't think so, no. Note, no additional information was provided. It is important to note that NP H contacted DON B to discuss PIs. DON B stated they identified this as an issue and took immediate steps to put this in PNC (past non-compliance) on [DATE]. However, DON B stated on [DATE] all weekly PIs measurements and assessments for all residents in house were lost. Surveyor asked DON B if she repeated the assessments and measurements. DON B stated, no. Subsequently, the deficient practices related to PIs are in current non-compliance. Example 2 R2 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R2 has an APOAHC (Activated Power of Attorney for Health Care). R2's Braden Assessment Scores are as follows: ,d+[DATE]: 15 (High Risk), ,d+[DATE]: 15 (High Risk), , d+[DATE]: 15 (High Risk), ,d+[DATE]: 15 (High Risk), ,d+[DATE]: 12 (High Risk), ,d+[DATE]:12 (High Risk), , d+[DATE]: 13(Moderate Risk), ,d+[DATE]: 13 (Moderate Risk) Braden Risk Levels: ,d+[DATE] At Risk, ,d+[DATE] Moderate Risk, ,d+[DATE] High Risk, ,d+[DATE] Very High Risk R2's Admission MDS (Minimum Data Set) dated [DATE], indicates R1 is severely cognitively impaired with a BIMS (Brief Interview for Mental Status) of 5 and requires extensive assistance of 2 for bed mobility, transfers, and toileting. R2 requires extensive assist of 1 for dressing and hygiene. R2's MDS indicates she is at risk for PI development and was admitted to the facility without any PIs. R2's Quarterly MDS dated [DATE], indicates R2 is moderately cognitively impaired with a BIMS of 9 and requires extensive assist of 2 for bed mobility, transfers, toileting, dressing and hygiene. R2 is an extensive assist of 1 for eating. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Visual /Bedside Kardex, dated [DATE], indicates the following for Skin: Ensure that heels are elevated while resident is lying in bed; use offloading boots while in bed; R2 encouraged to lay down between meals; Pressure relieving mattress/air mattress as ordered R2's comprehensive care plan indicates the following: (Date Initiated [DATE]) R2 has unstageable pressure injury to sacrum and stage 3 pressure injury to L (left) heel and potential for impairment to skin integrity and is at high risk for pressure injury development r/t (related t) incontinence limited mobility, decrease in nutritional intake, DM 2 (diabetes mellitus type 2) *sacrum is closed* dressing is for preventative measure (Date Initiated: [DATE]); Goal: R2's pressure ulcers [sic] will show improvement by next review period unless comorbidities cause unavoidable decline (Date Initiated [DATE], Target Date: [DATE]); Interventions: Ensure that heels are elevated while resident is lying in bed; use offloading boots while in bed; Change bedding/clothing if moist; Dietary Consult as needed; Encourage/assist R2 reposition when in wheelchair every ,d+[DATE] hours; Encourage/assist with turning and repositioning every ,d+[DATE] hours; Wheelchair pressure reduction cushion; Administer pain medication as ordered; Alternating air mattress to bed; Educate resident/family/caregivers of causative factors and measures to prevent skin injury; Weekly skin evaluation / report significant changes / evaluate every 7 days per policy; R2 encouraged to lay down between meals (All interventions implemented [DATE] with the exception of this last intervention Initiated [DATE]) On [DATE], R2's TAR (Treatment Administration Record) the following intervention was added: Offloading boots to bilateral feet while in bed. This is being signed out. On [DATE] R2's TAR the following intervention was added: Reposition q (every) 2 hours while in bed every shift. This being signed out. R2 developed a Stage 3 PI to her Left Heel on [DATE]. Measurements (in centimeters) are as follows: [DATE]: 1.7 x 3.20 x 0.10 Pink or red non-granulating 75%, Slough loosely adherent 25% [DATE]: 1.0 x 2.90 x 0.10 Pink or red non-granulating 75%, Slough loosely adherent 25% [DATE]: 1.0 x 1.50 x 0.10 Pink or red non-granulating 75%, Slough loosely adherent 25% [DATE]: 1.0 x 1.5 x 0.10 Pink or red non-granulating 75%, Slough loosely adherent 25% [DATE]: 0.50 x 1.00 x 0.10 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% [DATE]: 0.50 x 0.50 x 0.10 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% ,d+[DATE]: 0.50 x 0.50 x 0.10 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% [DATE]: 0.40 x 0.40 x 0.10 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% [DATE]: 0.30 x 0.40 x 0.10 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% [DATE]: 0.30 x 0.40 x 0.10 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% (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	08/31/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]: 1.70 x 2.5 x 0 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% Area has a clear fluid filled blister around some of site [DATE]: 1.70 x 2.5 x 0 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% [DATE]: 1.70 x 2.5 x 0 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% [DATE]: 1.70 x 2.5 x 0 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25%% [DATE]: 1.50 x 1.50 x 0 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% [DATE]: 1.50 x 1.50 x 0 Non-blanchable [CONDITION(S)] 75%, Pink or red non-granulating 25% *[DATE]: 1.0 x 1.0 x 0.10 - Slough non-adherent 100%; Note, this is a change of condition for R2 as the PI is 100% slough and there is undermining. The facility did not consult with R2's Physician/NP. *[DATE]: 1.5 x 1.5 x 0.10 - Slough non-adherent 100% - R2's PI increased in size; the facility did not consult with R2's Physician/NP. *[DATE]: 3.50 x 5.0 x 0.10 - NECROTIC 90%, bright pink or beefy red 10% - Note, from ,d+[DATE] - [DATE] is 15 days in between measurements and the PI worsened. The facility did not consult with R2's Physician/NP. *[DATE]: 10.50 x 9.0 x 0.30 - NECROTIC 90%; Odor: Yes. The facility contacts NP H to notify her of R2's worsening Left Heel PI thirty (30) days after the change in condition of R2's PI. Under RN Review Comments RN F documented the following note: [DATE] 12:18 PM - Call made the NP (NP H) to make aware that area has spread larger on heel. New treatment order was given for [MEDICATION(S)] and change daily. NP (NP H) will have resident seen at wound clinic. R2's family called and made aware of changed [sic] of site. New order for Prosource. [DATE]: 10.0 x 11.0 - Eschar, boggy, mild odor - Note, this is PA K's (Physician Assistant) assessment and measurement which is a 5.0 cm discrepancy from the facility's measurements the following day (below). , d+[DATE] is 12 days in between PI measurements and assessments and the PI worsened from [DATE]. *[DATE]: 10.0 x 6.0 x 0 - NECROTIC 100% - Note, from ,d+[DATE] - ,d+[DATE] is 13 days in between PI measurements and assessments and the PI worsened from 90% necrotic to 100% necrotic. Note, on [DATE] R2's PA K (Physician Assistant) assessed and measured R2's PI to her Left Heel: 10.0 x 11. 0 cm eschar, boggy, mild odor. Note, this is a 5.0 cm difference in measurements. On [DATE] R2's PA K had an initial visit with R2, documenting the following PIs: Left Inferior Ischium 5.0 x 6.0 cm 75% necrotic tissue and 25% yellow slough, malodorous (The facility has no documentation of this PI prior to PA K discovering the PI on ,d+[DATE]) Superior Right Buttock 2.0 x 2.75 cm with mild necrotic tissue (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Left Foot (Heel): 10.0 x 11.0 cm eschar, boggy, mild odor Great Plantar Toe with Eschar Right Foot (Heel): DTI (Deep Tissue Injury) Pressure Ulcer of Left Heel: Unstageable s/p (status post [MEDICAL RECORD OR PHYSICIAN ORDER] It is important to note, on [DATE] the facility documented R2's Left Heel PI with 100% slough. On [DATE] the facility again documented the PI with 100% slough. On [DATE] the facility documented R2's PI as 90% necrotic. The facility went two (2) weeks without measuring and assessing R2's PI. The current standard of practice indicates PIs are to be measured weekly. It was not until [DATE] when R2's PI increased significantly in size that the facility contacted NP H. NP H updated R2's treatment when she was notified. The facility did not identify the change in condition of R2's PI for thirty (30) days (from ,d+[DATE]-,d+[DATE]). From [DATE] to [DATE] the facility went thirteen (13) days without measuring and assessing R2's PI and the PI worsened from 90% eschar to 100% eschar. 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 - Actual harm 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 that each resident receives adequate supervision and assistance devices to prevent accidents in 2 of 3 residents (R5 and R3) reviewed for fall concerns. Staff did not implement the appropriate fall interventions when providing care for R5. R5 required staples to the back of her head after falling from bed. R3 did not have fall interventions in place when he fell from bed and hit his head, loosening his teeth. Surveyor observed fall interventions were not in place, and staff was not aware that R3 was a fall risk. This is evidenced by the following: Example 1 R5 is a long term care resident that was admitted to the facility on [DATE]. R5's diagnoses include cognitive delay and [CONDITION(S)]. R5's most recent MDS (Minimum Data Set) dated 6/7/21 states that R5 has a BIMS (Brief Interview for Mental Status) of 0/15 indicating severe cognitive impairment. R5 also requires extensive assistance for bed mobility, transfers, and toilet use. R5's CNA Kardex states, in part: Provide bariatric air mattress with wedges under to create wingtip type mattress for boundary identification, frequent checks to ensure proper positioning with R5 centered in her bed, .floor mat beside bed. Bed mobility: Physical Assist, Bathing: Physical Assist, Dressing: Physical Assist. R5's care plan dated 12/30/20 states, in part, The resident has a communication problem r/t (related to) [CONDITION(S)]. The staff will anticipate needs for this resident .Ensure/ provide a safe environment: Soft call light in reach .Bed in lowest position and wheels locked. R5 had a fall on 8/13/21 at 7:15 PM. The Report of Resident Fall states, Summoned by CNA (Certified Nursing Assistant) to residents [sic] room. Resident was lying on her back with a pool of blood. Assessed resident laceration on to the back of her head. Placed her in bed with help of the CNA. CNA stated he had left the resident unattended for less than a minute to grab a towel. R5 was sent to the ER (emergency room) for evaluation and treatment. R5 returned to the facility after receiving staples to the back of her head. It is important to note that the facility was unable to provide R5's ER notes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/17/21, Surveyor interviewed LPN C (Licensed Practical Nurse). Surveyor asked LPN C to explain the details of R5's fall on 8/13/21. LPN C stated she was at the nurse's station when the CNA asked her to come assess R5. The CNA reported to her R5 had fallen out of bed. The CNA stated he had put her to bed, left the room to get a towel, and R5 rolled out of bed on to the floor. Surveyor asked if R5's bed was in the low position, LPN C stated it was not in the low position and it was just below waist height. Surveyor asked LPN C if the fall mat was in place, LPN C stated no. Surveyor asked LPN C if the wedge wings were in place, LPN C stated R5 has them but they were not in place at that time due to the CNA getting her ready for bed. On 8/17/21 at 2:34 PM, Surveyor observed R5 sitting in her room, in her Broda chair with her call light on the bed, not within her reach. On 8/17/21 at 2:35 PM Surveyor interviewed CNA D. Surveyor asked CNA D if he thought that R5 could reach her call light, CNA D stated no, I do not. On 8/18/21, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what her expectation is for staff regarding the implementation of fall interventions, DON B stated she expects staff will follow those interventions. Surveyor asked DON B how she ensures staff are aware of fall interventions, DON B stated they are on the CNA Kardex and they are documented in the care plan. Surveyor asked DON B if she would have expected R5's fall interventions to be in place prior to her fall, DON B stated yes. Example 2 R3 was admitted to the facility on [DATE] with diagnoses of CHF ([CONDITION(S)]), Type 2 Diabetes, stroke, and [CONDITION(S)] (paralysis to one side of the body). R3' most recent MDS dated [DATE] documents a BIMS of 10/15 indicating moderate cognitive impairment. R3 also requires extensive assist for bed mobility, transfers, and toilet use. R3"s care plan dated 11/27/19 states, in part: R3 is a high risk for falls r/t weakness, history of falls, impulsivity, incontinence, polypharmacy, and vision. Interventions .Dycem added to (underneath) wheelchair cushion, bed in low position, CB to be assessed and changed out for soft touch call light, gripper socks to be in place at all times, assure gripper socks are on feet and encourage use when not in place as resident tolerates, landing strip on open side of bed to prevent injury. R3's CNA Kardex states, in part: CB (call bell) to be assessed and changed out for a soft touch call light, assure gripper socks are on feet and encourage use when not in place as resident tolerates, landing strip on open side of bed to prevent injury. Nurse's notes on 8/6/21 state Summoned to room per CNA, resident noted on floor lying in front of bed on back. R3 had an unwitnessed fall on 8/6/21. The facility's Report of Resident Fall does not give a summary of events. It does state R3 sustained minor injury; his front teeth were loose and R3 stated he hit his head on the floor. R3 was sent to the ER for evaluation. The ER notes the facility reported R3 had an approx. [sic] 4 foot fall from a hospital bed that was elevated in the air A small lac (laceration) noted on the upper gums. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's bed was not in the low position, as directed in the plan of care, at the time of this fall. On 8/17/21 at 9:40 AM, Surveyor observed CNA E perform incontinence cares with R3. Upon entering R3's room, Surveyor observed the bed was not in low position, R3 had on regular socks, and there was no landing strip on the open side of the bed, and the call light is not a soft touch call light. Surveyor also looked in R3's wheelchair, no Dycem found under wheelchair cushion. On 8/17/21, Surveyor interviewed CNA E. Surveyor asked CNA E how she knows what residents are fall risks, CNA E stated the information is in the care plans, computer system, and sometimes the nurse will let them know. Surveyor asked CNA E how she knows what interventions have been put into place, CNA E stated if it's in the room, it should be being used. Surveyor asked CNA E what fall interventions are in place for R3, CNA E stated she was unsure and she didn't believe R3 was a fall risk. CNA E stated R3 doesn't have a fall mat and she has never seen one in R3's room.