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	06/02/2022

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not permit each resident to remain in the facility and not transfer or discharge the resident from the facility. This occurred for 2 of 3 residents (R13 and R14). R13 and R14 were given an involuntary discharge. The facility did not care plan, monitor and reassess R13 and R14 to show they were a danger to others in the facility. R13 and R14 were discharged to a hotel without adequate reasoning. Findings include: Example 1 R13 was admitted to the facility on [DATE]. His diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . On [DATE], R13 was given an involuntary discharge notice by the facility stating the reason for discharge: *Your health has improved and you no longer need the services of this facility or the short term care period for which you were admitted has expired *Your health and/or safety and/or the safety of others is endangered by your remaining at this facility R13's care plan does not mention alcohol or any specific dangerous behaviors that endanger him or any other residents. The only targeted behavior regularly monitored by the facility was refusal of cares. The facility documented the following incidents and behaviors in progress notes for R13 prior to being issued the involuntary discharge: *[DATE] at 1:52 AM: Resident had two empty cans of beer in his room. Resident spilled beer on his clothing and asked the CNA [Certified Nursing Assistant] to assist him in changing his clothes. He would not disclose the name of the person who gave him beer. (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*[DATE] at 3:04 AM: Staff heard a very loud bang coming from res rm. Res [Resident] pulled BR [Bathroom] alarm where res was observed on his back with his towards the BR door. The toilet is noted to be cracked in several pieces. Blood (sm amt) was noted inside of commode. Res reported the toilet broke when he sat down harder then normally. RN notes res smells of alcohol When asked if he intoxicated res laughed and pointed to his drawer asking staff to recover his alcohol. Res reported hitting his head when he fell , 911 emergency contacted. EMT [Emergency Medical Technician] arrived and transferred res to the Hospital as res requested. Res is his own person requested no contacts be informed of incident. Writer left message for MD via call center. DON updated via message. [DATE] at 6:18 AM: Resident noted drinking Old Milwaukee beer outside in smoking area during night. Writer went out in attempt to see if more was out there and none found. [DATE] at 11:51 PM: Writer went out to the gazebo at approximately 2035 [8:35 PM] to check if patient was outside .Pt was sitting at the gazebo. Writer said to patient: I was looking for you to take your meds. Patient stated I am not taking any meds. When writer went closer, She observed a bottle between his thighs and he was smoking his cigarettes. Writer asked Pt: What is that bottle between your thighs. Patient stated My juice. Writer asked What kind of juice is it? Can I take a look? Pt lifted the bottle and it had a writing: E&J? Bottle had liquids that was already half way. Writer asked patient Did you drink all this alcohol? Patient answered Yes I did, and I am not giving my [NAME] to you. Writer educated patient about the importance of his medications and some of his diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . He stated: I don't give of F. {word}. People die any ways. Something is always going to kill you. Patient continued: Today is my birthday and no one can stop me from doing what I want. I am a grown A {word} man and no body going to tell me what I can or can not do. Writer acknowledged patient, that it was her responsibilities to make sure he is safe and understands the consequences of said behaviors. Patient stated :I don't care. Writer offered taking him back inside facility but he declined .patient came back in facility at 2119 [9:19 PM] and went back out at 2140 . [9:40 PM]. [DATE]at 11:32 PM: Resident sitting by nurse's station swearing loudly, being belligerent and smelling of alcohol. Resident later noted passing Styrofoam cup to two residents to drink from by dining room doors, on the way out to the smoking area. Writer waited for resident and two peers to go outside and check on them. It was noted that the Styrofoam cup was placed on railing of the smoking gazebo, so all could reach and amount of fluid in cup greatly diminished from when seen prior to going out. Writer stated to residents that writer had 95% inclination of thinking there was alcohol in cup. Resident changed subject and no one denied it. [DATE] at 1:46 AM: Resident noted to be loud, and hanging out at nurse's station, which he has done in the past when intoxicated. Resident left nurse's station but did not take Styrofoam cup with him. Writer picked up Styrofoam cup and removed the lid and cup reeked of alcohol. [DATE] at 10:56 PM: Writer found cup when clearing nurse's station, near computer. Writer found Styrofoam cup across from the nursing computer. Cup reeked of the same alcohol and was the same type cup as writer witnessed resident drinking from last night. Writer did not witness resident drinking from cup on this occasion. Resident is belligerent, swearing and slurring words again this shift. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 11:07 PM: This nurse observed resident sitting by the nurse's station, in the middle of the building, in his wheelchair, leaned back, with his head back and eyes closed. Appeared to be sleeping. Resident smelled of alcohol and had a cup of liquid, with a lid and straw in it, sitting on the desk next to him. The facility failed to implement interventions to assist R13 with his alcohol use or other interventions to assist R13 and prevent an involuntary discharge. R13 was discharged to a local motel on [DATE]. Example 2 R14 was admitted to the facility on [DATE]. His diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . On [DATE], R14 was given an involuntary discharge notice by the facility stating the reason for discharge: *Your health has improved and you no longer need the services of this facility or the short term care period for which you were admitted has expired *Your health and/or safety and/or the safety of others is endangered by your remaining at this facility R14's care plan, dated [DATE] states, Focus: Resident is requesting to have alcoholic beverages .Goal: the resident will consume alcohol within the limits set by the provider .Interventions: May have 2 servings of alcohol per day . It should be noted that this is the first mention or documentation of R14 and alcohol use since his admission. No documentation was provided stating he had used or requested alcohol before this time. The following PHQ scores were documented for R14: [DATE]: 10 (moderate depression) [DATE]: 10 (moderate depression) [DATE]: 10 (moderate depression) [DATE]: 12 (moderate depression) [DATE]: 9 (mild depression) R14 is a smoker. The facility conducts smoking risk evaluations to determine if residents are safe to smoke. R14's smoking assessments were documented on [DATE], [DATE], [DATE], [DATE], and [DATE] and determined him to be a safe smoker. The facility documented the following progress note for R14: (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*[DATE] at 3:50 AM: Writer heard very loud yelling and cursing coming from a male, writer ran to hallway observed res chasing a CNA with his right hand up in the air as if he was about to strike aide. Writer loudly yelled for res to stop and calm down. Writer asked res what happened res reports someone stole 20 dollars from me. Writer was able to assist res in calming down however res continued to call staff cunts, [OBSCENITY] es and whores. Writer asked res to go outside and calm down as he kept making threatening remarks to aides I'll f*** one of you b**** up. Resident eventually walked outside and was calmer. Resident smelled of alcohol and appeared in my nursing judgement to stumbling with gait and words. Upon returning back into building res started cursing loudly calling staff and other residents b**** even walking into room [ROOM NUMBER] engaging in a verbal altercation with resident because resident asked if he would quiet down. Writer noticed resident walking around smoking a cigarette writer asked resident several times to put out cigarette resident stated make me. Writer called 911 who came out spoke with resident and asked resident to stay in room and sleep off intoxication. Resident screamed and cursed at police calling them names. Police left resident continued to wheel out of room calling staff names. DON updated, resident eventually grew tired. In addition, the facility documented an incident which occurred around the same time. On [DATE], a female resident stated R14 had approached her on the morning of [DATE] at approximately 3:00 AM, grabbed her face and put his tongue in her ear. The facility began investigating the incident. As part of the investigation, the facility interviewed the victimized resident, who stated the incident scared her. Additionally, 6 other residents, as well as 6 staff, were interviewed regarding R14. No other residents had any concerns or fears with R14 and no staff had had any concerns or behavioral problems with R14. A nurse practitioner came to the facility on [DATE] due to R14's intoxication and notes multiple bottles of vodka were found and removed during the visit. Additionally, the nurse practitioner notes R14 was smoking in the building (see progress note from [DATE]) Additional progress notes documented for R14: *[DATE] at 5:08 PM, Social Services Note: Met with resident with regional nurse to discuss behaviors last evening. Offered to meet with resident in office, he declined and insisted we meet with him in the presence of the roommate. Immediately became angry and defensive, blaming the nurse from last night for his behavior despite him being disruptive to the police as well. Explained to resident that under no circumstances would he be allowed to remain in this facility and put other residents and staff at risk which is what this behavior from last evening did. Explained to him that he no longer has the permission from the Dr. to go out on pass or LOA [Leave of Absence]. If he displays these behaviors again we would be issuing a 30 day involuntary discharge. He was every despondent, mocking and condescending throughout the conversation. Stated he did want to leave but has nowhere to go, stated he had a home but his wife is in it and they are getting divorced so he can't go there. He denies having any family he can live with. He has an income from the reservation but they have a [AGE] year waiting list for housing. Social services will be following up in the morning with low income housing application. Resident does not have a community care partner to assist in placement. Reinforced to him again, that if he is choosing to remain here until he finds a place to live, he would be following our rules. Resident vocalized understanding .will have behavior contract completed to be signed by resident. [DATE] at 4:58 PM: Resident signed Behavior and Conduct Contract and agrees to not consume alcohol and to not have contact with female resident from incident occurring on [DATE]. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It should be noted, R14's care plan was not updated, but rather still stated he could consume alcohol up to 2 drinks per day. Additionally, physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . [DATE] at 1:26 AM: Nurse was looking for resident to give medications to. Repeatedly went back to resident room and found resident not there. Staff checked smoking area and did not find resident outside. Staff began searching facility and found resident passed out in his wheelchair in one of the lounges. Writer woke resident up and resident smelled strongly of alcohol, ran chair into two tables and door frame while trying to exit room. A brief time later, when PM nurse went to administer medications, resident was again passed out in his wheelchair. [MEDICATION(S)] held due to intoxication, on-call doctor notified. Writer went into resident's room in attempt to get resident to go to sleep for safety, resident refused. Resident started to talk about diabetes and began getting agitated .speech slurred. [DATE] at 4:33 PM: Police Department in facility to issue this resident a ticket for Disorderly Conduct. The facility added the following to R14's care plan on [DATE]: Resident has potential to be physically aggressive related to poor impulse control. No further incidents were documented or recorded between R14 and the victimized resident from [DATE]. R14 was discharged on [DATE] to a local motel. The following should be noted: *R14 had no documented behaviors from the time of admission, other than care refusal, until [DATE]. *R14 was visited by the nurse practitioner on [DATE], who notes, Socially he is going through a divorce, has not seen his children for months. He is waiting for housing funding and placement. On [DATE], Surveyors interviewed residents regarding R13 and R14. No residents had any safety concerns or issues with R13 or R14. No concerns were voiced by any residents in regards to R13 and R14 on the facility's grievance log. Additionally, no staff voiced concerns or felt R13 or R14 were a danger to others. SSD H (Social Services Director), RN I (Registered Nurse), CNA J (Certified Nursing Assistant), RN L, RN M, CNA N, and MW O (Maintenance Worker) all stated that they had not seen or heard of R13 or R14 being a danger or abusive to any other residents. CNA G and LPN K (Licensed Practical Nurse) were aware of the incident involving R14 on [DATE], but had not had any other problems or complaints from other residents. Similarly, all staff interviewed stated that R13 liked to drink and he would get loud at the nurse's station, but no staff were aware of, or had heard of, R13 yelling, being abusive, or creating problems for other residents in the facility. On [DATE] at 3:34 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who stated R13 and R14 were involuntarily discharged due to drinking and causing commotion in the facility. Additionally, NHA A stated residents in the facility were terrified but was unable to elaborate who was terrified or provide any documentation of residents who were terrified or scared of R13 and/or R14. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13 and R14 were known alcohol abusers. The facility did not have any documented behavioral concerns with R14 from the time he was admitted on [DATE] until [DATE]. The facility allowed R14 to consume alcohol as of [DATE] and after the events of [DATE], there is no evidence the facility reassessed R14 to identify any potential triggers or behavioral interventions that could potentially assist R14 to prevent future incidents from occurring. R13 was known to consume alcohol and be loud at the nurse's station, but no staff or residents had any safety concerns with him and the facility did not care plan or track any specific, targeted behaviors in relation to consuming alcohol or preventing the behaviors they felt were creating a nuisance in the facility. R13 and R14 were involuntarily discharged to a hotel with no support services or appropriate discharge planning.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide and document sufficient preparation and orientation to ensure safe and orderly transfer or discharge from the facility for 3 (R6, R13 and R14) of 3 residents reviewed for discharge. Example 1 R6 was admitted to the facility on [DATE] with diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . R6 attended Physical Therapy, Occupational Therapy, and Speech Therapy during her stay and her skilled nursing services ended on 10/16/21. R6 was discharged to her daughter's home on 10/18/21. R6's Comprehensive Care Plan did not include a Discharge Care Plan which addressed discharge plans or goals. R6's Initial Care Management form completed for a meeting on 9/1/21 indicates Resident's Planned Discharge Destination at the time was home, and a typed note in section 1a. stating Describe other completed by the facility reads, unsure at this time, residents daughter is involved and will assist as needed. Section 6. Environmental Barriers Impacting Discharge Plan indicates R6 has Steps to enter and Steps inside, and 6a. Describe other Environmental barriers indicate, current home has stairs. 7. Additional pertinent information related to discharge destination and/or IDT Team (Interdisciplinary Team) follow up items: (optional) reads, resident and daughter [daughter's name] states that home is not safe for the resident. They are planning so [sic] sell residents home and have her move into an apartment or ALF [Assisted Living Facility], will begin process of cleaning home now. Section F of the form indicates the following were in attendance, Resident, Resident Representative, Nursing, Social Services, Therapy. At the time of this meeting, R6's anticipated discharge date was 9/29/21. An Ongoing/Discharge Care Management form was completed for a meeting on 9/28/21. This form includes the following information: Has the resident's discharge destination or caregiver plan changed? No. Additional pertinent Caregiver information and/or IDT [Interdisciplinary Team] follow up items: resident and family continue with plan to sell home and move to an apartment or ALF. Additional pertinent mobility information: resident is showing improvement and is able to ambulate greater than 300ft with contact guard assist and 4ww [Wheeled Walker]. Anticipated discharge date : 10/12/21. Another Ongoing/Discharge Care Management form was completed for a meeting on 10/7/21 which includes the following information: Has the resident's discharge destination or caregiver plan changed? No. Additional pertinent Caregiver information and/or IDT Team follow up items: residents daughter is getting her home ready to sell and resident plans to d/c [discharge] to an apartment or ALF. Additional pertinent mobility information: resident is improving but continues to fatigue easily remains standby/contact guard assist with ambulation is ambulating using 4ww and able to ambulate up to 300ft. Anticipated discharge date : 10/19/21. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's Nursing Facility Discharge Summary dated 10/18/21 by the provider reads, in part. Her stay at [facility name] was relatively uneventful. Continued to make progress with therapy and has been deemed fit for discharge. Her discharge was rather abrupt . she opted to discharge to her daughter's home versus continuing to private pay while definitive placement was found. She is hoping to move into an assisted living facility versus an apartment as her home is currently on the market and she will not be returning there. Spoke with her daughter, [daughter's name]. [Daughter's name] frustrated that it seems the discharge was abrupt and sudden and they had no time to make plans. She saw several assisted living facilities over the weekend and has an appointment later today to look at another one. Her plan is for her mother to see [sic] with her for a short amount of time while placement is found. On 5/25/22, at 3:15 PM, Surveyor spoke with SSD H (Social Services Director) regarding R6's discharge from the facility. SSD H stated, I do remember discharging her to her daughter's, not assisted living. I believe she was planning on leaving and returning to her original living arrangement, but then it was up in the air as to where she would discharge to. Family was involved and participated in care conferences. I do recall this was their first time in dealing with a nursing home stay and they were overwhelmed with all the moving parts. It all was a bit abrupt. R6 was discharged abruptly without an orderly discharge. Example 2 R13 was admitted to the facility on [DATE]. His discharge care plan, initiated 10/20/20, states he wishes to return home with his mother and that he will be discharged with home health services. R13 was involuntarily discharged on [DATE] to a local motel, sharing a room with R14. R13 did not have an orderly or safe discharge plan. Example 3 R14 was admitted to the facility on [DATE]. His discharge care plan, initiated on 8/28/20, states he wishes to discharge back to the park he was living at with friends or find an apartment. The care plan also states R14 will be discharging with home health services, therapy services and community services. R14 was involuntarily discharged on [DATE] to a local motel, sharing a room with R13. R14 did not have a safe or orderly discharge plan. On 5/26/22 at 8:50 AM, Surveyor interviewed SSD H (Social Services Director), who stated R13 and R14 were discharged to a local motel and that neither received any home health, therapy or community services as stated on their discharge care plans.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not implement an effective discharge planning process that focused on the resident's discharge goals and needs, including caregiver support and referrals to local contact agencies to effectively transition them to post-discharge care for 3 of 3 residents reviewed for discharge planning (R13, R14, R6). The facility did not develop a discharge care plan for R6. R6 was also not provided with any information on local Assisted Living Facilities (ALFs) and no referrals were made to local ALFs for R6, despite documentation that R6 planned to discharge to an apartment or ALF. R13 did not receive the services as stated on his discharge care plan. R14 did not receive the services as stated on his discharge care plan. This is evidenced by: The facilities Policy and Procedure titled, Discharge Care Plan Guideline, revised 5/3/2018, states, Purpose: This facility promotes and supports a resident centered approach to care. The purpose of this guideline is to define and set expectations regarding discharge care planning in the facility to ensure that the process is conducted with the resident and/or resident representative as active partners, focusing on the resident's goals and preparation, as well as coordination with the interdisciplinary team and the comprehensive assessment, to prepare the resident for person-centered care following discharge. The policy's section titled, Guideline, reads, It is the guideline of this facility that residents will be evaluated for their discharge goals, preferences and care needs to meet their goals. The evaluation information will be used to develop a comprehensive discharge care plan. The resident will be re-evaluated periodically to identify changes and the discharge care plan will be modified to reflect any changes. The care plan will be developed by the interdisciplinary team, including the resident's physician, a registered nurse with responsible for the resident [sic], a nurse aid responsible for the resident, other staff or professionals in disciplines determined by the resident's needs or requested by the resident, a member of the nutrition services staff and to the extent practicable, the resident and their representative. The resident will be periodically reassessed to identify changes that require modification of the discharge plans and update the plans as needed. The resident and representative will be provided with the final discharge care plan. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose section of the policy reads, The interdisciplinary team shall prepare a comprehensive discharge care plan with the resident and resident representative to assist the resident to reach their discharge goal. The procedures within the policy include, in part. 3. Comprehensive Care Plan - Discharge Plan Update a. The Interdisciplinary Team will re-evaluate the Discharge Care Plan on a regular basis at a minimum via the RAI process or more often as needed, with the resident and resident representative, to identify any need for modifications and will update the plan of care to reflect changes. 4. Discharge b. If the resident desires returning to the community, document any referrals to Local Contact Agencies or other appropriate entities for the purpose of discharge (if applicable). c. Update the resident's comprehensive care plan and discharge plan (if applicable) with any information received form referrals to local contact agencies or other appropriate entities. d. If a resident is planning to be discharged to another Skilled Nursing Facility, Home Health Agency, Inpatient Rehab Facility, Assisted Living, or a Long Term Care Hospital, assist resident and resident representative in selection of a post acute care provider using standardized data on quality measures and data on resource us as available. 5. Documentation. d. Relevant resident information will be incorporated into the discharge plan to facilitate implementation and avoid unnecessary delays in resident discharge or transfer. e. The Discharge Care Plan as part of the comprehensive care plan and correlating documentation will be maintained in the medical record per guideline. 6. Orientation for transfer/discharge - The facility will provide the resident with sufficient preparation and orientation to the upcoming discharge to ensure the discharge is safe and orderly. Example 1 R6 was admitted to the facility on [DATE] with diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . R6 attended Physical Therapy, Occupational Therapy, and Speech Therapy during her stay and her skilled nursing services ended on 10/16/21. R6 was discharged to her daughter's home on 10/18/21. R6's Comprehensive Care Plan did not include a Discharge Care Plan which addressed discharge plans or goals. R6's Initial Care Management form completed for a meeting on 9/1/21 indicates Resident's Planned Discharge Destination at the time was home, and a typed note in section 1a. stating Describe other completed by the facility reads, unsure at this time, residents daughter [NAME] is involved and will assist as needed. Section 6. Environmental Barriers Impacting Discharge Plan indicates R6 has Steps to enter and Steps inside, and 6a. Describe other Environmental barriers indicate, current home has stairs. 7. Additional pertinent information related to discharge destination and/or IDT Team (Interdisciplinary Team) follow up items: (optional) reads, resident and daughter [daughter's name] states that home is not safe for the resident. They are planning so [sic] sell residents home and have her move into an apartment or ALF (Assisted Living Facility), will begin process of cleaning home now. Section F of the form indicates the following were in attendance, Resident, Resident Representative, Nursing, Social Services, Therapy. At the time of this meeting, R6's anticipated discharge date was 9/29/21. (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Ongoing/Discharge Care Management form was completed for a meeting on 9/28/21. This form includes the following information: Has the resident's discharge destination or caregiver plan changed? No. Additional pertinent Caregiver information and/or IDT (Interdisciplinary Team) follow up items: resident and family continue with plan to sell home and move to an apartment or ALF. Additional pertinent mobility information: resident is showing improvement and is able to ambulate greater than 300ft with contact guard assist and 4ww (Wheeled Walker). Anticipated discharge date : 10/12/21. Another Ongoing/Discharge Care Management form was completed for a meeting on 10/7/21 which includes the following information: Has the resident's discharge destination or caregiver plan changed? No. Additional pertinent Caregiver information and/or IDT Team follow up items: residents daughter is getting her home ready to sell and resident plans to d/c [discharge] to an apartment or ALF. Additional pertinent mobility information: resident is improving but continues to fatigue easily remains standby/contact guard assist with ambulation is ambulating using 4ww and able to ambulate up to 300ft. Anticipated discharge date : 10/19/21. R6's Nursing Facility Discharge Summary dated 10/18/21 by the provider reads, in part. Her stay at [facility name] was relatively uneventful. Continued to make progress with therapy and has been deemed fit for discharge. Her discharge was rather abrupt . she opted to discharge to her daughter's home versus continuing to private pay while definitive placement was found. She is hoping to move into an assisted living facility versus an apartment as her home is currently on the market and she will not be returning there. Spoke with her daughter, [daughter's name]. [Daughter's name] frustrated that it seems the discharge was abrupt and sudden and they had no time to make plans. She saw several assisted living facilities over the weekend and has an appointment later today to look at another one. Her plan is for her mother to see [sic] with her for a short amount of time while placement is found. On 5/25/22, at 3:15 PM, Surveyor spoke with SSD H (Social Services Director) regarding R6's discharge from the facility. SSD H stated, I do remember discharging her to her daughter's, not assisted living. I believe she was planning on leaving and returning to her original living arrangement, but then it was up in the air as to where she would discharge to. Family was involved and participated in care conferences. I do recall this was their first time in dealing with a nursing home stay and they were overwhelmed with all the moving parts. On 5/26/22, at 8:20 AM, Surveyor spoke with SSD H and asked, when the plan changed for R6 to go to an ALF or apartment instead of returning home if any ALFs were consulted. SSD H stated, I don't believe I sent any referrals for [R6]. Surveyor asked SSD H if she recalled why there were no referrals sent, and she indicated she did not remember that far back. Surveyor asked SSD H what her usual process was for a resident who was expected to be a short term stay and potential discharge to ALF. SSD H indicated she would start by giving families a list or directory of local ALFs and let them start considering their options. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/26/22, at 10:40 AM, Surveyor spoke to DON B (Director of Nursing) to ask who was responsible for starting the discharge process. DON B stated, The Social Worker (SSD H). Surveyor asked when did discharge care planning begin, and DON B indicated, It starts the minute I get the referral. We meet within 48 hours after admission and the discharge plan is always a part of the discussion. She (SSD H) does referrals to ALFs for anyone who would potentially be transitioning to one. Surveyor asked DON B if she was aware of why this was not done for R6, and DON B stated, I don't know, but she went home with her daughter. Surveyor indicated to DON B there were multiple meetings documented that discussed her plan to discharge to an apartment or an assisted living facility. DON B stated, [Social Services Director] was very new at the time. She does an excellent job and is very detailed with the planning process now. Example 2 R13 was admitted to the facility on [DATE]. His discharge care plan, initiated 10/20/20, states he wishes to return home with his mother and that he will be discharged with home health services. R13 was involuntarily discharged on [DATE] to a local motel, sharing a room with R14. R13 did not have a dischrge plan. Example 3 R14 was admitted to the facility on [DATE]. His discharge care plan, initiated on 8/28/20, states he wishes to discharge back to the park he was living at with friends or find an apartment. The care plan also states R14 will be discharging with home health services, therapy services and community services. R14 was involuntarily discharged on [DATE] to a local motel, sharing a room with R13. On 5/26/22 at 8:50 AM, Surveyor interviewed SSD H (Social Services Director), who stated R13 and R14 were discharged to a local motel and that neither received any home health, therapy or community services as stated on their discharge care plans. Both R13 and R14's comprehensive care plans indicate their discharge care plans were cancelled on 12/21/21.

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not complete a discharge summary when a discharge was anticipated for 2 of 3 residents (R13 and R14). R13 and R14 did not have a recapitulation of stay, were not discharged with the services stated on their discharge care plans, and the facility did not have a plan for how they would address the physical needs of R13 and R14. Findings include Example 1 R13 was admitted to the facility on [DATE] and has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . His discharge care plan, initiated 10/20/20, states he wishes to return home with his mother and that he will be discharged with home health services. Additionally, his care plan states he needs physical assistance for bathing/showering, bed mobility, dressing and toileting due to left side weakness. R13's most recent, completed Minimum Data Set (MDS), dated [DATE], states R13 needs one person physical assist with bed mobility, transfers, walking, dressing, and personal hygiene. R13's Brief Interview for Mental Status (BIMS) was a 14, indicating he is cognitively intact. His 12/9/21 MDS does not indicate what level of functional support he requires (all sections are marked N/A). R13 also did not participate in the BIMS portion of the MDS. R13 was involuntarily discharged on [DATE] to a local motel, sharing a room with R14. The facility completed a Recapitulation of Stay document for R13. The document states, Resident no longer requires skilled nursing and is appropriate to return to independent living, is returning home and his comprehensive care plan goals are to successfully return to independent living. The form does not detail the resident's course of treatment while residing in the facility and diagnoses. Example 2 R14 was admitted to the facility on [DATE]. His discharge care plan, initiated on 8/28/20, states he wishes to discharge back to the park he was living at with friends or find an apartment. The care plan also states R14 will be discharging with home health services, therapy services and community services. Additionally, his care plan states he requires a sit to stand mechanical lift for transfers. His most recent MDS, completed on 12/9/21, states he needs one person physical assist for dressing, toilet use and personal hygiene. R14 was involuntarily discharged on [DATE] to a local motel, sharing a room with R13. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility completed a Recapitulation of Stay document for R14. The document states, Resident no longer requires skilled nursing and is appropriate to return to independent living, is returning home and his comprehensive care plan goals are to successfully return to independent living. The form does not detail the resident's course of treatment while residing in the facility and diagnoses. On 5/25/22 at 2:10 PM, Surveyor interviewed R13, who stated that he and R14 were discharged together to share a room at a local motel and told by NHA A (Nursing Home Administrator) that they would be helping each other. R13 stated he was unable to get into the shower at the motel and, on a few occasions during the 1 week at the motel, was unable to get back into bed and had to call maintenance staff at the hotel to help him get into bed. Additionally, R13 stated he needed to get help from a friend of his mom's because he could not bathe himself. On 5/26/22 at 8:50 AM, Surveyor interviewed SSD H (Social Services Director), who stated neither resident was discharged with any services. Additionally, SSD H stated the Recapitulation of Stay document is the primary document used in the discharge process. On 5/26/22 at 2:10 PM, Surveyor interviewed NHA A (Nursing Home Administrator). When asked how both residents were to perform the tasks needed in accordance with their care plans at a motel, NHA A stated that R13 and R14 were independent and did not need skilled services any longer, which was part of the reason both residents were involuntarily discharged . The facility did not complete a recapitulation of stay for either R13 or R14 and did not provide the services as stated on the discharge care plan.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident received needed supervision to prevent accidents for 1 of 3 residents (R1) reviewed for falls from a total sample of 19. R1, who is on an antiplatelet medication and may bruise and bleed more easily, was transferred via a Hoyer lift with assist of 1, instead of 2 as care planned. R1 fell out of the Hoyer lift and struck his head on the floor. The likelihood for harm was then exacerbated when the certified nursing assistant (CNA) moved R1 into bed by himself without waiting for a nursing assessment. The fall caused a hematoma to his posterior head and fractured C6 osteophyte (is the sixth cervical (neck) vertebra from the top; bone spurs often form where bones meet each other - this is typically caused by [CONDITION(S)]) and created a likelihood for more serious injury. Facility failure to ensure each resident is transferred safely created a finding of immediate jeopardy that began on 5/23/22. Surveyor notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) of the immediate jeopardy on 5/26/22 at 3:12 PM. The immediate jeopardy was removed on 5/26/22. However, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. This is evidenced by: The Facility's Policy and Procedure entitled Fall Evaluation Safety Guideline with an effective date of 11/28/17 documents, in part: .Fall Evaluation- A fall evaluation is used to identify individuals who have predicting factors for falls. This evaluation is completed upon admission, quarterly, annually and with a significant change in condition .Procedure .3. Initiate, review and revise the fall care plan as appropriate, with new or discontinued interventions . The Facility's Policy and Procedure entitled Guideline on Sara (stand lift) and Maxi (full body lift), undated, documents the following, in part: .Maxi-lift .It is intended to be used in hospitals, nursing homes or other health care facilities where the patient: Sits in a wheelchair, Has no capacity to support himself/herself, Cannot stand unsupported and is not able to bear weight; not even partially, Is dependent on the caregiver in most situations OR where the patient: is passive, might almost be bedridden, is often stiff or has contracted joints, is totally dependent on caregiver . The Manufacturer's Manual documents the following, in part, on page 19: .Preparing the Lift for Use NOTE: Although .recommends that two assistants be used for all lifting preparation, transferring from, and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 is a long-term resident of the facility. R1 has the following diagnoses: ataxia following nontraumatic intracerebral hemorrhage (impaired coordination), limitation of activities due to disability, muscle weakness (generalized), cerebral infarction (stroke), weakness, other lack of coordination, unspecified lack of coordination, other muscle spasm, cramp and spasm, [CONDITION(S)] unspecified affecting right dominant side (paralysis of one side of body (right)), [CONDITION(S)] (muscle jerks), acquired absence of right leg above knee, extrapyramidal and movement disorder, and [CONDITION(S)]. It is important to note that R1 has many diagnoses that indicate he is unable to support himself and/or move or not move with intention. R1's care plan documents the following, in part: R1 requires assist for ADL self-care performance deficit r/t [related to] spasms and contractures .Transfers: Resident requires Total/Hoyer mechanical lift . This care plan is dated 10/26/20. R1 has limited physical mobility r/t Stroke and RBKA [right below knee amputation] .Right upper extremity positioned on lap with carrot or rolled up wash cloth in hand. Offer V shaped pillow behind head, tilt in space feature to help from sliding out of chair, recline slightly when resting .Transfers: R1 requires use of a Hoyer lift for all transfers . This care plan is dated 10/26/20. Resident is at risk of falls due to limited mobility, [CONDITION(S)] [stroke] and RBKA . This care plan is dated 10/26/20. R1 is at risk for falls r/t comprehension, Gait/balance problems, Incontinence, H/O (history of) Falls, H/O [CONDITION(S)], H/O LBKA, Use of Psychotropics . This care plan is dated 10/26/20. The resident has an amputation of RLE [right lower extremity] . This care plan is dated 1/31/20. R1 has potential chronic pain r/t involuntary movement and loss of limb [surgical amputation] right below the knee amputation . This care plan is dated 10/26/20. R1's CNA care plan documents the following, in part: .Safety, 5/24/22: Resident is to have 2 staff to assist with Hoyer transfers for all transfers . .Transferring, Transfers: Resident requires Total/Hoyer mechanical lift; Transfers: R1 requires use of a Hoyer lift for all transfers . R1's Transfer Ability Tool dated 6/9/21 documents Transfers: Resident requires Total/Hoyer mechanical lift. It is important to note that this tool does not indicate that R1 could safely be transferred with the Hoyer lift and 1 assist. R1's Minimum Data Set's (MDS) document the following, in part: MDS dated [DATE]- .Transfer, total dependence of two persons physical assist . MDS dated [DATE]- .Transfers, total dependence of two persons physical assist . R1's Physician Orders contain: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[MEDICATION(S)] 75 mg QD (daily) with a start date of 6/10/21. Antiplatelet medications are used to prevent the formation of blood clots that can lead to [CONDITION(S)] and stroke. Common side effects include bleeding, bruising, etc. R1's Nurses' Notes document the following, in part: 5/23/22 at 9:19 PM- Situation: R1 .Resident had a fall. The fall was witnessed. Resident slipped from Hoyer lift pad during transfer Background: Resident is NOT on Anticoagulant or Antiplatelet medication .History or current complaint is: None Assessment: BP [blood pressure] 145/72 - 5/23/2022 17:40 [5:40 PM] Position: Lying l[left]/arm P [pulse] 59 - 5/23/2022 17:40 Pulse Type: Regular R [respirations] 20 - 5/23/2022 17:40 T [temperature] 97.5 - 5/23/2022 17:22 [5:22 PM] Route: Temporal Artery O2 [oxygen saturation] 94 % - 5/23/2022 17:40 Method: Room Air BS [blood sugar] 174.0 - 7/15/2021 11:08 [11:08 AM] Pnl [pain level] 0 - 5/23/2022 19:25 Pain scale: Numerical Resident has NO injury. No pain is noted. Neurological changes are NOT noted. Recommendation/Response: Neuro Evaluation form Facility fall protocol. It is important to note that R1 is on an antiplatelet medication, [MEDICATION(S)]. 5/23/22 at 9:25 PM- Post-Fall: Total Fall Risk Score is: 11 Fall risk scored above 5, resident is at a HIGH risk for falls. BP 145/72 - 5/23/2022 17:40 Position: Lying l/arm T 97.5 - 5/23/2022 17:22 Route: Temporal Artery P 59 - 5/23/2022 17:40 Pulse Type: Regular R 20.0 - 5/23/2022 17:40 O2 94.0 % - 5/23/2022 17:40 Method: Room Air Pnl 0 - 5/23/2022 19:25 Pain scale: Numerical Resident is receiving anti-coagulant medication. The resident does not receive anti-diabetic medications. Resident is receiving [CONDITION(S)] medication. Resident is receiving anti-hypertensive medication. There have not been any changes in the medication. There is no new pain, post fall. There is not a noted pattern to falls. The resident does not have any injury noted. New interventions for this fall that are being implemented: Proper use of h/l [Hoyer lift] Pain Eval: Pain Scale is at: 0. Location is: Pain Score is: Satisfactory pain management / Continue with current plan of care. Skin Observation: Resident does not have a new skin issue. Slight redness and swelling to top of head. Neuro Observation: Resident is alert. Resident is NOT oriented x4; oriented to person, Pupils: PERRLA [pupil, equal, round, reactive to light and accommodation]. Eye evaluation is at resident baseline. Speech is clear. Responds to simple commands. Verbalizes appropriately. There are no noted changes in baseline speech clarity. Right side hand grasp has weakness. There are no changes to the baseline hand grasp strength. Movement and sensation intact in left arm. Movement and sensation intact in left leg. Resident has right side weakness r/t [CONDITION(S)] Evaluation indicates no changes from baseline. It is important to note that the Facility indicates Proper use of Hoyer lift as new intervention for this fall and it is important to note that resident did have an injury post fall of hematoma to posterior head. 5/23/22 at 9:50 PM- Note Text: This evaluation is being completed related to post fall Fall Risk Score is: 11 Fall risk scored above 5, resident is at a HIGH risk for falls. Only Fall Risk Evaluation in R1's medical record is dated 5/23/22 (which was completed post fall from Hoyer). It is important to note that the first question on this evaluation is Has the resident had a recent known fall? This question is answered no. This document is not accurately completed which gives R1 a lower fall risk score. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/23/22 at 10:22 PM- Note Text: resident slipped from Hoyer lift while being transferred from chair to bed. Fall was witnessed. Resident hit his head on the floor. Denied pain, no non-verbal indicators of pain noted. Assisted to bed. Remain alert and verbally responsive. Able to move left arm and leg. Right side weakness in place r/t [CONDITION(S)] along w/ [with] right side aka. Neuros initiated and wnl [within normal limits]. Slight swelling and redness noted to top of head. Md [Physician], family and DON notified. 5/24/22 at 1:48 PM- Note Text: Resident complained of pain of 9 today and said he just didn't feel right. Applied ice pack to bump on top/back of head from fall the night before but was not effective in relieving pain per resident. Called .NP [Nurse Practitioner] regarding resident's pain. Advised that his BP was 179/83, P 55 and pain level was 9. She said she was coming to the Facility in about an hour and to call her if things changed .NP assessed resident and advised that he be sent to the ER [emergency room]. EMS [Emergency Medical Services] arrived about 1030 and took him . EMS report dated 5/24/22 documents the following, in part: .a [AGE] year-old male that had fallen the previous night and was now experiencing high blood pressure and head pain .The pt. [patient] states that he is experiencing pain in his head and neck. Facility staff reports that the pt. was being transferred last night using a Hoyer lift at around 2125 [9:25 PM] when there was a mechanical failure with the lift and the pt. fell approximately 3 feet .The staff reports that the pt. has had a previous stroke and he suffers from stroke deficits which includes slurred speech and [CONDITION(S)]. EMS asks staff if the pt. is presenting at his baseline and staff responds with yes however, they report that the pt. is answering questions slightly slower than normal. EMS asks questions of staff regarding the pts [patient's] medication usage and preferred hospital destination, but staff is unable to answer those questions. EMS is given a packet from staff containing that information .It is noted that the pt. does take a blood thinner. A report regarding the fall last night is also given to EMS from staff. In the report, staff indicated that proper fall protocol was followed and that the pt. was not taking a blood thinner . ER report dated 5/24/22 documents the following, in part: .1. Fracture of an osteophyte from the C6 inferior endplate .follow up in 2 weeks .Clinical Impressions: Fall from ground level, Osteophyte of cervical spine, and Acute traumatic injury of cervical spine .Risk of Complications, Morbidity, and/or Mortality- Presenting problems: high, Diagnostic procedures: high, and Management options: high .Neurosurgery Brief Consult Note- Was called about his patient regarding C6 anterior osteophyte fracture sustained after being dropped from Hoyer lift .Viewed imaging that demonstrated non-displaced anterior inferior C6 osteophyte fracture . Recommendations as follows: 1. Please place patient in rigid collar to be worn at all times. 2. Please obtain upright cervical spine x-rays (AP and lateral) in the collar. 3. Can follow up in Neurosurgery clinic .in 2 weeks with upright cervical spine x-rays to be completed at that visit . 5/24/22 at 6:58 PM- Note Text: Return from .ER @ 1515 [3:15 PM]. Resident was sent to ER for c/o [complaints of] pain r/t fall on 5/23/22. Return w/neck brace in place due to fracture. No other orders noted. Will continue to observe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/25/22 at 4:22 PM, Surveyor interviewed CNA E. Surveyor asked CNA E if he could explain how R1 fell ; CNA E explained that he was putting R1 to bed with the Hoyer lift, it was a freak accident that the strap came undone; CNA E further explained that he couldn't get the legs of the lift under the bed so he pulled with the lift toward him and that caused him to rock back and forth in the sling and then he fell . CNA E stated I tried my best to catch him when he hit the floor he was screaming. Surveyor asked CNA E what happened next, CNA E said he moved the lift, ran to get another CNA, looked for the nurse, then returned to R1's room and put him back to bed. Surveyor asked CNA E if he was aware that he should not have moved R1 before the nurse could see him. CNA E stated, I just wasn't thinking about it, I just wanted to get him up off the floor. Surveyor asked CNA E if he was alone transferring R1. CNA E stated the other CNA was feeding residents so I thought I could get him in bed. Surveyor asked CNA E what strap came undone causing R1 to fall. CNA E said the left side by his head. Surveyor asked CNA E if R1 was supposed to be transferred with 1 assist. CNA E said he doesn't work down that hall much. When Surveyor asked CNA E if residents that use the Hoyer lift are supposed to be transferred with 1 or 2 assist, CNA E stated always with two. Surveyor asked CNA E if he transferred R1 alone back to bed from the floor after fall, CNA E said yes. Surveyor asked CNA E how R1 was after he was back in bed, CNA E replied he was his normal self, he did have a bump on the back of his head but had not C/O pain. CNA E further explained that he worked the NOC shift that night and R1 slept fine and was laughing and joking with me. Surveyor asked CNA E if he had received education regarding this incident, CNA E stated no, DON B had called and discussed what happened with him, but he had not received any education. On 5/25/22 at 3:35 PM, Surveyor interviewed LPN D (Licensed Practical Nurse). Surveyor asked LPN D to explain the events surrounding R1's fall from 5/23/22; LPN D explained that she was on break. CNA E came to her upon her return and told her R1 had slipped out of the sling of the Hoyer lift; LPN D further explained that upon entering R1's room he was already back in bed. R1 was alert, talking and denied pain, he did have a lump to posterior head. Surveyor asked LPN D if CNA E transferred R1 by himself. LPN D said through conversation with CNA E, yes, that was the case, he was alone with R1 during transfer. Surveyor asked LPN D if she had any other contact with R1 after the fall, LPN D said yes, she was here when he returned from theER on [DATE]. Surveyor asked LPN D what R1's condition was upon return, LPN D stated he had a hard collar on, she gave him some Tylenol, he was drowsy, he seemed comfortable but didn't eat as well as he usually does. Surveyor asked LPN D if the neuro checks had been resumed upon R1's return. LPN D said no. On 5/25/22 at 2:09 PM, Surveyor interviewed RN C (Registered Nurse). Surveyor asked RN C to explain R1's condition prior to being sent to theER on [DATE]; RN C explained that she knew he had fallen and hit his head the night prior (5/23/22). She completed his neuro check noting his BP to be a little high and R1 C/O pain to his head rating it 9 (on a 1-10 pain scale); RN C further explained that she applied ice to the lump on the back of his head and called the NP. Surveyor asked RN C if it was unusual for R1 to C/O head pain, RN C stated yes. Surveyor asked RN C what the NP said when she called her. RN C said NP said she would be in the facility within an hour and would assess R1 at that time and to call her if anything changed. Surveyor asked RN C what transpired after the NP assessed R1. RN C stated she told me to send him to the ER. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/26/22 at 8:40 AM, Surveyor interviewed RN F. Surveyor asked RN F what occurs after a resident falls. RN F explained they are asked about pain, there is a complete assessment (head to toe) including ROM to all extremities, shoulder shrugs, move legs independently, see if legs have any external or internal rotation, begin neuro checks; if going to ER leave on floor and have 911 called otherwise back to bed, administer Tylenol or other pain medication, call Provider, DON B and residents' representative. Surveyor asked RN F how many staff should transfer a resident that uses the Hoyer lift, RN F said all residents that transfer with a Hoyer lift are 2 assist. On 5/26/22 at 10:05 AM, Surveyor interviewed CNA G after observing her and another CNA perform a Hoyer lift transfer. Surveyor asked CNA G how many staff should transfer a resident that uses the Hoyer lift. CNA G stated always 2 staff with Hoyer lift transfers. Surveyor asked CNA G if there is anything else that should always be done when using a Hoyer lift. CNA G said cross the straps at the legs, unless they are the short ones that are used for residents with amputations. Transferring a resident with a full body mechanical lift without an assessment indicating it was safe to complete such transfer with one staff resulted in a fall with fracture and created a reasonable likelihood for serious harm occurring. This led to a finding of Immediate Jeopardy (IJ). The IJ was removed on 5/26/22 as the facility implemented the following action plan: Resident was evaluated at the hospital on 5/24/22. After extensive testing, the only finding was fracture of a C6 osteophyte. A cervical collar was placed. No further treatment was ordered. The resident returned from the hospital on 5/24. The resident's care plan was updated to reflect two-person assist for Hoyer transfers. Residents requiring a Hoyer lift transfer have the potential to be affected. The facility has reviewed the care plans for any residents requiring a Hoyer lift transfer to ensure that the care plan states two-person assist. Re-education and Hoyer lift competencies have been completed with the facility nursing staff. Education also included the facility post fall guidelines. Any remaining nursing employees will be required to complete education and competencies prior to working on their assigned unit. Lift competencies will include new staff on hire and annual competencies. Audits will be completed by the DON or designee on varying shifts, including observations of transfers for residents requiring a Hoyer lift. Transfer audits will be done 3 times per week, one on each shift, for 4 weeks, then results taken to QAPI [Quality Assurance Plan Improvement]. The DON is notified of all falls in the facility. She will provide assessment, instruction, and guidance to licensed nurses following a fall as needed. The DON will review fall incidents daily Monday through Friday to ensure that the resident's care plan was followed, and established facility post-fall guidelines were implemented. This will be done for 4 weeks, and results brought to QAPI. Audits will be discussed during the IDT [interdisciplinary team] QAPI monthly meetings. The IDT team will determine when consistent compliance has been met and audits can be discontinued. The NHA is responsible for this task.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents are free of any significant medication errors for 1 of 3 residents (R8) reviewed for medication errors. R8 received Pfizer COVID Booster vaccination on 11/12/2021 of 5 times the required dose without preparing to dilute dosage. DON (Director of Nursing) B did not fill out a Medication Error Report. Evidenced by: Pfizer-BioNTech Manufacturer guidelines Fact Sheet for Healthcare Providers Administering Vaccine (https://labeling.pfizer.com/ShowLabeling.aspx?id= &format=pdf), states, in part: Dilution: Dilute the vial contents using 1.8 mL of sterile 0.9% Sodium Chloride Injection, USP (not provided) to form the Pfizer-BioNTech COVID-19 Vaccine. ONLY use sterile 0.9% Sodium Chloride Injection, USP as the diluent. This diluent is not packaged with the vaccine and must be sourced separately. Do not use [MEDICATION(S)] 0.9% Sodium Chloride Injection or any other diluent. Do not add more than 1.8 mL of diluent. After dilution, 1 vial contains 6 doses of 0.3 ml. Facility Manual Title: LTC Facility's Pharmacy Services and Procedures Manual, Effective Date: 12/01/07, Revision Date 05/01/2010 states, in part: 4. Administration Errors: . 4.8 Dose preparation error: Facility staff incorrectly formulates or manipulates a drug product before administration (e.g., incorrect dilution or reconstitution) . R8's MAR (Medication Administration Record) Pfizer-BioNTech COVID-19 Vacc Suspension 30MCG/0.3ML (COVID-19 mRNA Vaccine (Pfizer)) Inject 0.3ml intramuscularly one time only for COVID-19 Vaccination Booster for 1 Day. Order Date 11/12/2021 R8's Medication Review Report indicates an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . On 5/25/2022 during entrance, Surveyor requested Medication Error Reports. On 5/26/2022 at 3:55PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she administered R8's COVID booster vaccination. DON replied, I don't know I give plenty of them Surveyor asked DON B if she could look it up and inform the Surveyor if she did and the type of vaccination. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/26/2022 at 4:30PM, DON B and NHA A (Nursing Home Administrator), DON B reports she did give 5 times the dose of COVID booster, and the manufacturer is Pfizer brand and nobody else received an error. DON B states the NP (Nurse Practitioner) was here and informed her and told DON B not to worry about it. DON B reports she obtained an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . DON B reports that pharmacy was in the facility at the time. DON B stated the pharmacy informed DON B that they see these errors, and discussion was held that the order needed to be diluted. DON B reports she went back and did find the dilution bottle in the bag and was so tiny. DON B reports that they are going to change how the label is read. Surveyor asked if DON B filled out an incident report DON B stated no. Surveyor asked DON B if R8 was informed of the medication error. DON B stated the resident is their own person and was informed. DON B reports she checked on the resident several times.