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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525330 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/18/2024 |
| NAME OF PROVIDER OR SUPPLIER Middleton Village Nursing and Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview and policy review, the facility failed to prevent staff to resident abuse for 1 (Resident (R) 4) of 1 resident reviewed for physical abuse when allegedly Licensed Practical Nurse (LPN)3 physically grabbed R4's arm and removed a dab/vape pen from R4's hand.</p> <p>Findings include:</p> <p>Review of R4's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and readmission was on 08/04/21 with diagnoses of multiple sclerosis, bipolar disorder, and anxiety disorder.</p> <p>Review of R4's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated resident was cognitively intact.</p> <p>Review of R4's Care Plan, located under the Care Plan tab of the EMR dated 04/25/23, revealed The resident has a behavior of ordering items that are potentially harmful to self or others. Interventions in place were to monitor for unsafe items and if found please hold for resident's family to pick up.</p> <p>Review of the facility's Grievance Form dated 02/14/24 revealed, R4 was upset that staff removed R4's dab/vape pen (portable vaping devices designed for users to consume an unspecified amount of cannabis concentrates) and locked it in the medication room with other residents' smoking materials.</p> <p>Review of a Nurse's Note, in the EMR, under the Notes tab written by LPN2 dated 02/14/24 at 6:42 PM indicated that an aide indicated a resident had a dab/vape pen. LPN3 went to retrieve it from the resident and the resident was very resistant to give it to him. LPN3 got the dab/vape pen from the resident and placed it in medication room.</p> <p>During an interview on 03/25/24 at 2:45 PM, R4 said LPN 3 came into his room and told him I know what you got under there and LPN3 grabbed a hold of his arm and pushed it to the side and took the dab/vape pen from his closed fist. He stated he felt violated. R4 stated that he did not report the incident to anyone at the facility but called the police and reported that his property was taken from him.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 03/26/24 at 3:29 PM, LPN 3 stated that staff told him that R4 had a dab/vape pen in his room. He went and got LPN2 and together they went into R4's room. LPN3 said R4 was initially argumentative and denied having the pen. R4 showed the pen to LPN3 in his hand and LPN3 told him he needed to take it. He said R4 started lifting his hand upwards towards LPN3, who said he placed his hand under R4 wrist, but he did not completely close his fingers to help stabilize R4's hand, He said R4 could pull away at any time and R4 voluntarily allowed LPN3 to take the pen from his hands. The next day floor staff told him the R4 called the police on him, and he was asked by the Administrator and Director of Nursing (DON) to explain what happened. He told them he had to take away R4 dab/vape pen. LPN3 stated that he was asked to fill out the grievance form and write a statement about what happened.</p> <p>During an interview on 03/27/24 at 9:01 AM the Social Services Director (SSD) said that Certified Nurse Aide (CNA) staff told her that R4 had a dab/vape pen. The SSD stated that R4 told her LPN3 took a hold of his arm, and turned his hand over and pulled the dab/vape pen out of his hands. She said that R4 had a closed fist and LPN3 pulled it out of his hands She said she reported that information to the Administrator and DON on 02/14/24.</p> <p>During an interview on 03/27/24 at 10:58 AM, CNA4 said that she worked the shift following the shift when the incident occurred. LPN2 told her that LPN3 took her into R4's room so she could witness LPN3 getting R4's dab/vape pen. She said LPN2 told her that LPN3 aggressively grabbed R4's dab/vape pen out of his hand. She asked LPN2 if the incident was reported, and she said yes. CNA4 said she talked to R4, and he told her that LPN3 forced the dab/vape pen out of his hand.</p> <p>During an interview on 03/27/24 at 11:57 AM, the DON said that she was aware there was an incident when LPN3 removed R4's dab/vape pen from his hand. She was not aware that R4 did not willing surrender the pen and that R4 was accusing LPN3 of physically taking it from him. She just thought R4 was upset that his dab/vape pen was taken away from him. The DON stated that she had LPN3 completed a grievance for the incident but did not report the incident to the State Agency (SA) or investigate the incident. After she was informed on 03/25/23 that R4 alleged LPN3 physically took his dab pen against his will, she reported the incident, suspended LPN3 and initiated an investigation.</p> <p>During an interview on 03/27/24 at 1:18 PM, LPN2 said CNA staff made her aware on 02/14/24 that R4 had a dab/vape pen in his possession. She went and got LPN3 and together they went into R4's room. LPN2 said they asked R4 about it and he taunted them by waiving the dab/vape pen in the air saying, You mean this? She said LPN3 took hold of R4's arm and grabbed it out of his hand. R4 did not willing surrender the pen. She said staff are not supposed to physically take things from residents and what LPN3 did was not appropriate it. She did not report it.</p> <p>Review of the facility's policy titled Abuse, Neglect, and Exploitation revised 01/05/2024, revealed, it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview and policy review, the facility failed to report 1 of 1 allegations to the State Agency (SA) that Licensed Practical Nurse (LPN)3 physically grabbed R4's arm and removed a dab/vape pen from R4's hand.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect, and Exploitation revised 01/05/2024, revealed, it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. , law enforcement when applicable) within specified timeframes, immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>Review of R4's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and readmission was on 08/04/21 with diagnoses of multiple sclerosis, bipolar disorder, and anxiety disorder.</p> <p>Review of R4's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated resident was cognitively intact.</p> <p>Review of the facility's Grievance Form dated 02/14/24 revealed, R4 was upset that staff removed R4's dab/vape pen (portable vaping devices designed for users to consume an unspecified amount of cannabis concentrates).</p> <p>During an interview on 03/25/24 at 2:45 PM, R4 said LPN 3 came into his room and grabbed a hold of his arm and pushed it to the side and took the dab/vape pen from his closed fist. He did not report the incident to anyone at the facility but called the police and reported that his property was taken from him.</p> <p>During an interview on 03/26/24 at 3:29 PM, LPN 3 said floor staff let him know that R4 had a dab/vape pen in his room. LPN3 went and got LPN2 and together they went into R4's room and told the resident he was not allowed to have the dab/vape pen. LPN3 stated that R4 started lifting his hand upwards towards LPN3, who said he place his hand under R4 wrist, but he did not completely close his fingers to help stabilize R4's hand, The next day floor staff told him that R4 called the police and he was asked by the Administrator and Director of Nursing (DON) to explain what happened. He told them he had to take R4's dab/vape pen away from him. He was asked to fill out the grievance form and write a statement about what happened.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 03/27/24 at 9:01 AM the Social Services Director (SSD) said that a Certified Nurse Aide (CNA) told her that R4 had a dab/vape pen. R4 told her LPN3 took a hold of his arm, and turned his hand over and pulled the dab pen out of his hands. She said that R4 said he had his fist closed and LPN3 pulled it out of his hands She said she reported that information to the Administrator and DON on 02/14/24.</p> <p>During an interview on 03/27/24 at 10:58 AM, CNA4 said she talked to R4 and he told her that LPN3 forced the dab/vape pen out of his hand.</p> <p>During an interview on 03/27/24 at 11:57 AM, the DON said that she was aware of the incident when LPN3 removed the dab/vape pen from R4's hand. She was not aware that R4 was accusing LPN3 of physically taking it from him. She just thought R4 was upset that his dab/vape pen was taken away from him. The DON stated that she did not report the incident to the SA. After she was informed on 03/25/23 that R4 alleged LPN3 physically took his dab pen against his will and she reported the incident to the SA.</p> <p>During an interview on 03/27/24 at 1:18 PM, LPN2 said that a CNA told her on 02/14/24 that R4 had a dab/vape pen in his possession. She went and got LPN3 and together they went into R4's room. She said LPN3 took a hold of R4's arm and grabbed it out of his hand. R4 did not willing surrender the pen. She said staff are not supposed to physically take things from residents and what LPN3 did was not appropriate it. She did not report the incident to anyone in the facility.</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview and policy review, the facility failed to thoroughly investigate 1 of 1 allegation's that Licensed Practical Nurse (LPN)3 physically grabbed R4's arm and removed a dab/vape pen from a resident's hand for one (Resident (R 4) of one resident reviewed for physical abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect, and Exploitation revised 01/05/2024, revealed, it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation. The Administrator will follow up with government agencies to report the results of the investigation when final within five working days of the incident, as required by state agencies.</p> <p>Review of R4's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and readmission was on 08/04/21 with diagnoses of multiple sclerosis, bipolar disorder, and anxiety disorder.</p> <p>Review of R4's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated resident was cognitively intact.</p> <p>Review of the facility's Grievance Form dated 02/14/24 revealed, R4 was upset that staff removed R4's dab/vape pen (portable vaping devices designed for users to consume an unspecified amount of cannabis concentrates).</p> <p>During an interview on 03/25/24 at 2:45 PM, R4 stated that LPN 3 came into his room and LPN3 grabbed a hold of his arm and took the dab/vape pen from his closed fist. R4 stated that he did not report the incident to anyone at the facility but called the police and reported that his property was taken from him.</p> <p>During an interview on 03/26/24 at 3:29 PM, LPN 3 stated that staff stated R4 had a dab/vape pen in his room. He went and got LPN2 and together they went into R4's room. LPN3 stated that R4 started lifting his hand upwards towards LPN3, who said he placed his hand under R4 wrist, but he did not completely close his fingers to help stabilize R4's hand, He said R4 could pull away at any time and R4 voluntarily allowed LPN3 to take the pen from his hands. The next day floor staff told him the R4 called the police on him, and he was asked by the Administrator and Director of Nursing (DON) to explain what happened. He told them he had to take away R4's dab/vape pen. LPN3 stated that he was asked to fill out the grievance form and write a statement about what happened.</p> <p>(continued on next page)</p> |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 03/27/24 at 9:01 AM the Social Services Director (SSD) stated that R4 told her LPN3 physically pulled the dab pen out of his hand. The SSD stated that she reported that information to the Administrator and DON on 02/14/24.</p> <p>During an interview on 03/27/24 at 10:58 AM, CNA4 stated that LPN2 told her that LPN3 took her into R4's room so she could witness LPN3 getting R4's dab/vape pen. CNA4 stated that LPN2 stated that LPN3 aggressively grabbed R4's dab/vape pen out of his hand.</p> <p>During an interview on 03/27/24 at 11:57 AM, the DON said that she was aware there was an incident when LPN3 removed R4's dab pen from his hand. She was not aware that R4 did not willing surrender the pen and that R4 was accusing LPN3 of physically taking it from him. She just thought R4 was upset that his dab/vape pen was taken away from him. The DON stated that she had LPN3 completed a grievance for the incident but did not investigate the incident. After she was informed on 03/25/23 that R4 alleged LPN3 physically took his dab/vape pen against his will, she initiated an investigation.</p> <p>The facility failed to thoroughly investigate this incident of staff to resident abuse.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262</p> <p>Based on staff interview, record review, document review, and policy review, the facility did not ensure staff responded appropriately to an alarm and provided adequate supervision to 1 of 2 (R5) residents reviewed for elopement.</p> <p>R5 was assessed by the facility to be at risk for elopement. He did wear a WanderGuard. On 12/18/23, R5 eloped from the facility and was found on facility grounds by staff. On 02/25/24, at approximately 04:26am, R5 eloped from the facility through an alarmed door. Staff responded to the alarm but did not look outside the door to determine if anyone was outside. Staff did not begin a room-by-room search until approximately 30 minutes later when it was noted R5 was not in the building. Law Enforcement was not notified of the missing resident for 2 hours. R5 was found at a gas station approximately 1.5 miles from the facility around 07:32am and returned him to the facility at 08:06am.</p> <p>The facility's failure to implement appropriate safety measures and provide adequate supervision to R5 created a finding of Immediate Jeopardy that began on 02/25/24. The Administrator, Director of Nursing (DON), and Nurse Consultant were informed of Immediate Jeopardy on 4/11/24 at 11:30 AM. The immediate jeopardy was removed and corrected on 02/25/24.</p> <p>Findings include:</p> <p>The facility's policy titled; Elopement/Unsafe Wandering dated 01/04/24 contains the following information: . 4. Procedure for Locating Missing Resident. a. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g., intimal alert code). b. Quickly determine if the resident is out on leave or pass. c. Initiate a rapid search of the building and the grounds. d. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department .</p> <p>The policy does not address how quickly to notify the police after a resident elopes from the facility and does not address to not turn off the door alarm until the resident is found.</p> <p>On 04/29/24 at 10:53am, the DON confirmed with Surveyor that this was the facility's policy prior to R5's elopement on 2/25/24 and that this is still the facility's policy. She said the policy was reviewed by Quality Assurance and Performance Improvement (QAPI) and the facility's corporate office and no changes were made to the policy.</p> <p>R5 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction due to occlusion or stenosis of right carotid arteries, dementia with agitation, cognitive communication deficit, muscle weakness, difficulty in walking, congestive heart failure, blindness of one eye, and hearing loss.</p> <p>R5 was ambulatory with the use of a rolling walker. R5 was mostly supervision or touching assistance with activities of daily living (ADLs).</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>R5's annual Minimum Data Set (MDS) assessment, with Assessment Reference Date (ARD) of 10/05/23, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 was cognitively intact.</p> <p>Upon a readmission on 10/23/23, R5 was assessed to be an elopement risk due to impaired safety awareness.</p> <p>R5's quarterly MDS assessment with an ARD of 01/05/24, indicated R5 had a decline in his cognition with a BIMS score of 8 out of 15 which indicated R5 was moderately cognitively impaired. The MDS indicated R5 had a history of wandering and exit seeking, wore a WanderGuard, had impaired balance and limited mobility, required a walker to ambulate, and was at risk for falls.</p> <p>R5's care plan included a problem of Elopement risk/wanderer due to impaired safety awareness initiated on 09/26/23, which indicated the following interventions: Staff aware of resident's wander risk, check WanderGuard placement and functionality every shift, encourage and assist resident to call his daughter from his room telephone, wander alert personal safety device on right ankle, offer food and fluids, resident enjoys coffee, engage in therapeutic conversation and encourage resident to visit/converse with other residents.</p> <p>R5's Visual/Kardex Report (Certified Nursing Assistant care card) dated 12/20/23 and provided by the DON (Director of Nursing) listed safety interventions of: check WanderGuard placement and functionality every shift, encourage and assist resident to call his daughter from his room telephone, ensure appropriate visual aids, glasses, are available, safety device wander guard to right ankle and mobility indicates uses walker.</p> <p>R5's Wander/Elopement Risk Evaluation dated 01/11/24 and provided by the DON indicated a score of 29. The document indicated, a score equal or greater than 6 is at risk. The document indicated R5 was physically able to leave the building on his own; R5 was independent with mobility; and his mode of locomotion was marked ambulatory.</p> <p>R5's EMR (electronic medical record) and investigative file provided by the DON contained the following attempted elopements:</p> <p>On 12/18/23, R5 eloped from the facility around 1:50 AM through the Harbor Hall dining room door which sounded an alarm. Staff responded to the door alarm sounding, looked outside the door, and located R5 and brought him back into the building.</p> <p>Following the 12/18/23 elopement, staff were educated and R5's care plan was updated to include approaches to offer food and coffee, encourage resident to visit with other residents, and engage in therapeutic conversation.</p> <p>Review of a facility investigation revealed that R5 had a second elopement on 2/25/24.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 02/25/24, R5 eloped from the facility's front doors triggering the alarm at 4:26 AM. According to Registered Nurse (RN) 3, on 02/25/24 he heard the alarm and went to the front door where Certified Nurse Aide (CNA) 3 was resetting the door alarm and told him everything was fine and that all the residents were in their beds. At approximately 5:00AM, CNA3 came up to him and said R5 was not in his room. RN3 got the other night nurse, LPN4, and they started doing a room-by-room search. RN3 stated that he called DON at 5:35AM. DON instructed RN3 to do a more thorough search of the facility. The facility notified the [NAME] Police at 7:05am.</p> <p>Surveyor reviewed the police report from the [NAME] Police and interviewed [NAME] Police Officer 1. The report revealed R5 was found at the Kwik Trip gas station approximately 1.5 miles from the facility at 7:32 AM. The police returned R5 to the facility at 8:06 AM.</p> <p>Interview with Police Officer 1 on 04/10/24 at 12:04 AM, confirmed the police station received the call from the facility at 7:02 AM and she took the call at 7:05AM. Police Officer1 confirmed that according to their records R5 was found at 7:32 AM and returned to the facility at 8:06AM.</p> <p>Surveyor reviewed the previous Administrator's five-day report dated 03/01/24, which indicates that based on camera footage, the resident left the facility via the front door at 4:26 AM.</p> <p>Surveyor interviewed the DON and the Maintenance Director on 04/09/24 at 9:54 AM, which revealed that the front entrance of the facility consisted of two sets of doors. The inner set of doors used to have WanderGuard sensors attached to the metal frame of the door. Above this set of doors is a motion detector. The Maintenance Director stated that he reviewed the camera footage for 02/25/24, which showed R5 coming down the hallway and prior to getting to the first set of doors, the motion detector detected the walker and opened the door. Once R5 went through this set of doors, the WanderGuard on R5's ankle triggered the alarm. The inner set of doors opens to a vestibule which then opens to the outer doors (external doors), which the Maintenance Director stated were unlocked at all times.</p> <p>During this interview, the DON and Maintenance Director stated that when the receptionist leaves at 8:00 PM, she locks the inner set of doors. The morning that R5 eloped, even though the motion sensor detected R5's walker, this set of doors should have been locked, the motion detector would not have been able to open the doors, and that a staff must have unlocked this set of doors and forgot to relock the doors and that was how R5 was able to exit the building.</p> <p>Both the DON and Maintenance Director stated that the first set of doors are locked at 8:00 PM and if a family member wanted to exit the building, a staff person would have to unlock the doors. They both stated that staff have the code to unlock the doors and they are to relock the doors until the receptionist arrives the next morning at 7:30 AM.</p> <p>On 04/09/24 at 2:13PM, the DON confirmed with Surveyor that the facility did not save the camera footage, the facility did not have a backup system to save the camera footage, and it was not uploaded onto the internet.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Surveyor interviewed RN3 on 03/27/24 at 10:11 AM. RN3 stated that when the alarm went off on 02/25/24, he immediately went to the front door and when he got there, CNA3 had disabled the code by entering the door code and told him everything was fine and that all the residents were in their beds. He said not even 5 minutes later, CNA3 came up to him and said R5 was not in his room. He got the other night nurse, and they started doing a room-by-room search. RN3 stated that he called the DON at 5:35 AM. The DON instructed RN3 to do a more thorough search of the facility.</p> <p>On 04/09/24 at 9:54 AM, Surveyor asked DON why there was a delay in contacting the police from 5:35AM to 7:05AM? DON stated that she wanted to exhaust all possibilities that they would find R5 in the facility. DON stated that she told RN3 to do a more thorough search of every room, locked closets, etc. to be sure that they searched everywhere.</p> <p>On 04/09/24 at 3:25PM, Surveyor interviewed LPN4 who stated that at midnight on 02/25/24, R5 came to the nurses' station and wanted to know if the man came with the money to pay for the steel. LPN4 stated she walked R5 back to his room and observed his room from the nurses' station until she started to pass medications. LPN4 stated that when the alarm went off, she went to the back door however, it was not alarming. LPN4 stated that she went to the front door, and no one was there. The door was not alarming.</p> <p>On 04/09/24 at 1:04PM, Surveyor interviewed R11 (R5's resident friend who lives in the facility) who stated on 02/25/24 at 4:07 AM, R5 came to her room and said he was leaving. R11 looked at her cell phone and told R5 that it was 38 degrees Fahrenheit (F) outside. R5 said he was going home. R11 stated that he was wearing two hooded sweatshirts, khaki pants, socks, and shoes. She said R5 had the hooded sweatshirt pulled over his head. R11 said that when RN3 came to talk to her on 2/25/24 at 5:15AM, she told RN3 that you better get out there and look, because R5 said he was going home. R11 said that he had a white bag and his rolling walker and that she could not convince him to stay in the facility.</p> <p>Review of a Nurse's Note, in the EMR, indicated: late entry for 02/25/24 at 6:30 AM, resident wandering out of facility and staff and law enforcement were actively looking for resident.</p> <p>During an interview on 03/26/24 at 10:29 AM, CNA1 said R5 wore a WanderGuard and would tell staff that he was going to work or to the store but could be easily redirected by staff. CNA1 stated she never observed him exit seeking or trying to get out of a door. She received a call while she was at home around 5:40 AM on the morning of 02/25/24 from the DON letting her know that R5 was missing. She drove to the facility along with another staff member and assisted staff in searching the inside and outside of the facility along with nearby streets and side roads. Sometime between 7 AM and 8 AM she heard that police had located R5 at a nearby gas station a few miles away from the facility. He had his walker with him. Upon return to the facility, R5 was placed on 1:1 supervision until he was discharged a few days later to another facility with a secure unit as per the Power of Attorney's wishes.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>During an interview on 03/26/24 at 11:15 AM, RN1 said R5 would usually walk around the facility with his walker stating he was going to work, and she would tell him that it was his day off and redirect him to something else. He was very receptive to redirection. She never saw him exit seeking but she thinks it was probably because he walked in circles around the wagon wheel (nurse station) and most likely did not know where the exits were located. On the morning of 02/25/24, she arrived at the facility about 5:15 AM through the main front door. As she was walking in another nurse asked her if she had seen R5, but she told them she had not. She did not remember seeing anyone outside or along the long driveway. She was informed that staff had been unable to locate R5. Law enforcement was contacted at some point. A little later in the morning staff were told police had found him about a mile or a mile and a half away. She did see him after he returned, and he was wearing winter wear that included pants and a jacket. There were no injuries, and he was placed on 1:1 supervision until he was discharged .</p> <p>During an interview on 03/26/24 at 12:35 PM, LPN 1 said R5 wore a WanderGuard and was always stating that he needed to go to work. R5 wandered around but he did not walk up to doors or try to open them. LPN 1 stated in the early morning of 02/25/24, around 5:35 AM, she received a phone call from the DON that R5 was missing. She immediately went to the facility and arrived at 5:50 AM to 5:55 AM and saw RN3 and RN1 outside. LPN1 stated that she assessed R5 when he was returned to the facility and that R5 had no new skin issues noted from incident. LPN1 confirmed that R5 was wearing a hooded sweatshirt, a sweatshirt underneath, khaki pants, socks, and shoes.</p> <p>During an interview on 04/09/24 at 4:45 PM, the DON stated that the Administrator told her to have LPN1 call the police at 6:45 AM. LPN1 confirmed that she called the police by using the facility's phone and dialing 911. LPN1 provided no evidence of what time she made the 911 call.</p> <p>During an interview on 03/26/24 at 12:35 PM, LPN2 said on 02/25/24 around 5:30 AM, he received a call from DON that R5 was missing and requested that he come to the facility. When he arrived, he assisted in searching for R5 both inside and outside the facility. Staff were in their cars driving around the area looking up and down streets. He and another staff reviewed the cameras and discovered R5 exited through the front lobby sliding doors. They were able to see R5 walking towards the dumpsters with his walker, and he had on pants, two sweatshirts, and a bag. At some point he walked out of range of the camera view, and they lost sight of him.</p> <p>During an interview on 04/09/24 at 10:00 AM, the Maintenance Director stated that he monitored the WanderGuard system weekly. The Maintenance Director showed documentation which indicated that the two doors with WanderGuard devices were functioning. The last time the two doors' WanderGuards were checked prior to R5's elopement was on 02/22/24. The Maintenance Director showed documentation that he evaluated all the other doors in the facility to ensure that they had a 15 second delay before releasing and sounding the alarm. The documentation showed the other doors were all functioning. Tour of the facility on 04/09/24 at 10:00 AM revealed the two doors' WanderGuard devices were functioning, and the other doors had a 15 second delay before they released, the door opened, and the alarm sounded.</p> <p>The Maintenance Director stated that after R5 was returned to the facility on [DATE], he moved the WanderGuard sensors that were attached to the door frame to the wall area before the first set of doors. With the WanderGuard sensor device in hand, he demonstrated that the first set of doors locked when the WanderGuard was nine feet from the door.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>The DON provided documentation that she had conducted in-service training on the facility's Wandering and Elopement Policy and Procedure starting on 02/25/24 daily times one week, then weekly times four week. Interview with nurses, CNAs, Rehabilitation Director, housekeeping, laundry, Business Office, and Activities Director revealed staff stated that they had attended an in-service training or completed the Relias training, and they were able to verbally state what to do when the door alarm goes off. Each stated that they would not turn off the alarm, would go outside and conduct a search of the property, search inside the facility and conduct a count of the residents.</p> <p>Review of RN3 and CNA3's personnel records revealed documentation that both had participated in elopement training on 01/31/24 which was prior to R5's 02/25/24 elopement. CNA3's file indicated that she was terminated as of 03/01/24. Review of CNA3's timesheet revealed the last day CNA3 worked at the facility was 02/25/24 at 6:05 AM.</p> <p>Currently there is one resident (R7) with a history of wandering but no active wandering or exit seeking behavior residing at the facility. R7's care plan had updated interventions in place to include wearing a WanderGuard.</p> <p>Review of the Wander/Elopement book revealed R7 was listed in the book. There was a book in the laundry, nurses' station, and rehab.</p> <p>The failure to supervise a resident who was able to elope from the facility created a reasonable likelihood for serious harm which created a finding of Immediate Jeopardy. The facility removed and corrected the immediate jeopardy on 02/25/24 when it completed the following:</p> <ol style="list-style-type: none"> 1. Resident's WanderGuard device was checked and was functioning properly. 2. All WanderGuards and WanderGuard/alarm doors were checked for functionality. No adverse findings noted. 3. Education of ALL staff on Wandering and Elopement Policy and Procedure was completed before next scheduled day of work. 4. Elopement Drills were conducted every shift for seven days, once a week on every shift for four weeks, then once a week every month for two months. 5. WanderGuard sensor was adjusted on the front doors. 6. All residents were reassessed for wandering and elopement risk. 7. All residents at risk for wandering and elopement were reviewed and reassessed by DON/designee to ensure accurate, appropriate plan of care was in place. 8. Elopement and wandering binders were reviewed and updated as needed. 9. WanderGuard sensors were relocated to capture a bigger radius. 10. Staff were educated and able to describe when doors are to be locked and how to lock and unlock the doors. <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>DON or designee conducted Elopement drills once a week on every shift for four weeks after initial seven days, then once a week every month for two months. All results were brought to QAPI and readdressed and tweaked as needed. Ad hoc education was provided when indicated.</p> <p>Audits were reviewed at the monthly QAPI meeting to determine trends or patterns of concern and/or if further education were needed and would continue until substantial compliance had been achieved.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 10 residents (R8) was using a continuous positive airway pressure (CPAP) machine as ordered by R8's Physician.</p> <p>Findings include:</p> <p>Review of R8's electronic medical record (EMR), census tab revealed an admitted [DATE]. Review of Physician orders in the EMR under the orders tab revealed an order for the resident to use .</p> <p>Review of R8's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/22/24 revealed a Brief Interview for Mental Status score of 15 out of 15 which indicated the resident was cognitively intact.</p> <p>Observation of R8's room on 03/25/24 at 10:30 AM revealed there was no CPAP near the resident's bedside.</p> <p>Interview 03/25/24 at 10:40 AM, R8 stated that she did not have a CPAP machine in her room to use at night.</p> <p>Interview on 03/26/24 at 1:30 PM, Licensed Practical Nurse (LPN)1 stated that R8 did not have a CPAP machine and that the physician was not notified of the inability to follow the physician's orders for the CPAP. LPN 1 confirmed the physician was not notified, the facility did not obtain the CPAP machine and that R8 did not use the machine as ordered,</p> <p>Interview with the Director of Nursing (DON) on 03/26/24 at 3:30 PM, the DON confirmed R8 did not have a CPAP machine available, and the physician was not notified of the facility's inability to follow the physician's orders.</p> | | |