STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads Care Center	965 McMillan Street Worthington, MN 56187

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on observation, interview and document review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours, and failed to ensure a copy was provided to the resident and/or representative for 2 of 3 (R3 and R6) residents reviewed who were new admissions to the facility. Findings include: R3's admission MDS dated [DATE], indicated R3 had severe impaired cognition, no depression, no hallucination but had delusions. R3 had diagnoses of Alzheimer's disease, dementia, anxiety disorder, and psychotic disorder. R3 had physical and verbal behaviors towards others one to three days and self-inflicting behaviors and wandering behaviors, four to six days. R3 required supervision to moderate assist with ADLs of shower/bathing, lower body dressing, and personal hygiene. R3 received antipsychotics and antianxiety medications. R3's physician orders dated 6/6/24, indicated the following: -lorazepam (antianxiety) 1 milligram (mg) every 12 hours as needed for anxiety, (start date 5/8/24); -memantine (medication used to slow dementia process), 10 mg twice daily, (start 5/7/24); -quetiapine fumarate (medication used to help with behaviors related to dementia) 50 mg at bedtimes for restlessness and agitation, (start date 5/8/24, stop date 5/10/24); -Rexulti (medications used to help with behaviors related to dementia) 1 mg daily for agitation and restlessness, (start date 5/10/24, stop date 5/25/24). -Rexulti 2 mg daily, (start date 5/25/24). Review of R3's progress notes dated 5/7/24 through 5/10/24, indicated the following behaviors: -5/7/24 at 1:01 p.m., R3 was uncooperative with eating and drinking, is exit seeking and stated she was going to slap staff in face if they do not let her leave. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/7/24 at 5:35 p.m., lorazepam 1 mg order obtained, and first dose given out of emergency kit for aimlessly wandering, looking though all exit doors, attempting to open said doors, and moving wheelchairs form closet doors trying to exit seek. Easily angered at staff, made mean remarks and comebacks when attempting to redirect. R3 raised her hand at NA at one point and called NA a Bitch. Follow up note with same date at 7:29 p.m., indicated medication was ineffective but R3 went to room and was sleeping. -5/8/24 at 9:00 a.m., R3 received lorazepam 1 mg due to increased anxiety/restlessness, exit seeking behaviors, wanting staff to open doors to let her walk home, anger would increase when staff refused. R3 grabbed back of RN-B's neck and squeezed tightly and scolded RN-B for not opening the door. R3 wanted staff to call sheriff so she could get her out of this prison. Follow up note for same date at 12:00 p.m., indicated medication was effective and R3 was sitting at the dinner table with a much calmer demeanor. -5/9/24 at 7:42 a.m., order for quetiapine 25 mg twice daily for restlessness and agitation received. -5/9/24 at 7:54 a.m., R3 received lorazepam 1 mg to promote calmer demeanor as was exit seeking and noted to have increased anxiety about being in new place. Follow up note at 1:00 p.m., indicted medication was effective as R3 sat at table and listened to activities but refused to participate. Continues to wander the halls frequently and attempted to open several doors but was easily redirected when alarm sounded. -5/9/24 at 2:38 p.m., R3 received lorazepam 1 mg, as was pacing, asking to go home. Follow up note at 4:20 p.m., indicated medication was ineffective as R3 continued to exit seek. Per note with same date at 9:34 p.m. , R3 continued her exit seeking behaviors until 8:30 p.m., when staff were able to assist R3 to bed as she was having increased difficulty with gait. -5/10/24 at 2:23 p.m., R3 received lorazepam 1 mg, as R3 was yelling and looking for exits. Follow up note at 3:44 p.m., medication was effective and R3 was resting. -5/10/24 at 4:10 p.m., seen by mental health provider. R3 was pacing the floor trying to get out of the unit. Mental health provider discontinued the quetiapine 25 mg and started Rexulti 1 mg daily and haloperidol 5 mg twice daily for delusional disorder. Review of R3's care plan identified the following: -ADL care plan dated 5/7/24, listed the activities of daily living (ADLs) task for bathing/showering, bed mobility, dressing, eating, personal hygiene/oral care, toilet use, transfer, and therapies, however, did not identity R3's self-performance level and/or required staff assistance. -Behavior care plan dated 5/10/24, did not identify what type of behaviors and lacked individualized interventions for R3's behaviors. During an interview on 6/6/24 at 12:46 p.m., family member (FM)-A indicated they had never received a copy of R3's baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's admission MDS dated [DATE], indicated R6's cognition was intact. R6 had diagnoses of hip fracture and anxiety disorder. R6 required moderate assist of staff with toilet hygiene, shower,/bathing, dressing lower body, put on/take off footwear and personal hygiene. R6 also required moderate assist with ambulation, bed mobility and transfers. Review of R6's baseline care plan dated 5/10/24, listed the activities of daily living (ADLs) task for bathing/showering, bed mobility, dressing, eating, personal hygiene/oral care, toilet use, transfer, and therapies, however, did not identity R6's self-performance level and/or required staff assistance. R6's care plan did not identify any behavior/diagnosis of anxiety or interventions to prevent or manage the anxiety. During an interview on 6/6/24 at 1:07 p.m., FM-B denied receiving a copy of R6's care plan and indicated R6 did not receive one either. During an interview on 6/6/24 at 9:41 a.m., nursing assistant (NA)-S stated this was her first day on the job, she was told verbally on how to take care of the residents and the other NA working with her wrote down on the care sheet how to assist each resident with their ADLs. NA-S further stated if there were questions she would ask the regular staff. During an interview on 6/6/24 at 11:39 a.m., assistant director of nursing (ADON) stated she was learning how to do the care plans. ADON further stated the floor nurses were to start the base line care plans upon admission from the admission assessment. ADON indicated the baseline care plan was the staff's guideline to implement immediate cares on how to assist the residents with their ADL's and included transfers and ambulation. ADON further stated the baseline care plans were not being done and the staff were told by word of mouth on how to care for residents. During an interview on 6/6/624 at 12:04 p.m., director of nursing (DON) stated was aware base line care plans were not being completed and given to the residents and/or their families/representatives. DON stated baseline care plans were necessary for the nursing assistants and nurses to refer to for caring for residents. The baseline care plans consisted of transfers, ambulation, and general cares for residents. It was her expectation the baseline care plans would be completed. Review of the facility's undated policy titled, Care Plan- Baseline indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. 3. the baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. 4. the resident and their representative will be provided a summary of the baseline care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on observation, interview and record review, the facility failed to ensure anxiety signs and symptoms were identified in their care plan to assist direct staff of when to administer these medications for 1 of 1 resident (R1) reviewed who used antianxiety medications. Finding include: R1 admission minimum data set (MDS) dated [DATE], indicated intact cognition, no depression, no hallucinations, or delusions. R1 had diagnoses of anxiety disorder and depression. R1 required minimal to maximal assist of two staff for most activities of daily living. R1 was receiving antidepressants (medications used to treat depression), and antianxiety (medication used to treat anxiety) medications. R1's physician orders dated 4/25/24, indicated the following: -bupropion oral tablet (antidepressant) 300 milligrams (mg) by mouth at bedtime, (start 4/25/24). -alprazolam (antianxiety) 1 mg, give 0.5 tablet by mouth every eight hours as needed for panic attack, (Start 4/25/24). -clonazepam (medication used to treat seizure and panic disorders), 1 mg, give 0.5 table by mouth every eight hours as needed for anxiety, (start 4/25/24). Review of R1's ADL care plan dated 4/25/24, listed the ADL tasks for bathing/showering, bed mobility, dressing, eating, person hygiene/oral care, toilet use, transfer and therapy, however, did not identify R1's self-performance level and/or required staff assistance. R1's care plan lacked acknowledgement of his diagnoses of anxiety and depression and what signs and symptoms staff were to monitor before administering his medications. Review of R1's medication administration records from 4/25/24 thru 5/31/24 indicated the following medication orders and administration dates and times: -alprazolam 1 mg, give 0.5 tablet every 8 hours as needed for panic attacks, (start 4/25/24, stop 5/31/240, administered 4/27/24 at 1:17 a.m. Was not administered in month of May. -clonazepam 1 mg 0.5 mg by mouth every eight hours as needed for anxiety, (start 4/25/24, stop 5/30/24), never administered. -clonazepam 1 mg, tablet twice daily for anxiety, (start 5/30/24, stop 5/31/24), administered on 5/30/24 at 6:00 p.m. and 5/31/24 at 9:00 a.m. -tramadol 50 mg 1 tablet every 6 hours as needed for severe pain until 5/24/22, (start 5/21/24, stop 5/22/24), administered 5/21/24 at 3:47 a.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-tramadol 50 mg 1 tablet every six hours as needed for pain until 5/24/22, (start 5/22/24, stop 5/24/24), administered 5/22/24 at 4:09 p.m. -tramadol 50 mg 1 tablet every 6 hours as needed for moderate pain for three days, (start 5/30/24, stop 5/21/24), administered 5/31/24 at 3:40 a.m. and 1:07 p.m. -bupropion ER 300mg at bedtime for depression, (start 4/25/24, stop 5/31/24), received daily while in facility. -acetaminophen 650 mg every 6 hours as needed for pain and fever, (start 4/27/24, stop 5/31/24); administered 4/27/24 at 1:36 am, 4/28/24 at 6:00 a.m. Did not receive in the month of May. Review of R1's progress notes from 5/17/24 thru 5/31/24 identified the following: -5/17/24 at 10:14 a.m., R1 stayed in bed all day, refused to get up. R1 using bedpan as stated too weak to stand up. Nurse gave him encouragement to continue to get stronger, but R1 refused. -5/17/24 at 11:23 p.m., R1 was upset and crying this evening related to not getting information about his discharge plan. R1 states Social worker was to come back and explain the plan to me. -5/18/24 at 12:32 a.m., R1 complaining of pain to his spine, rated 9/10 when he moves. R1 told nurse 2-3 days ago staff repositioned him inappropriately, now he was having a lot of pain when he moves. R1 refused acetaminophen or hot pack. R1 requested to go to emergency room and sent at 12:30. -5/18/24 at 5:49 a.m., R1 returns from emergency room at 5:35 a.m., R1 had CT scan of back and nothing abnormal found, pain mediation was given and under control. Potassium levels were low and was given oral supplement and brought it back to normal. R1 told emergency staff that he did not want to return to facility, but they had n reason to admit him. -5/20/24 at 9:46 p.m., R1 arrived to facility via ambulance from the emergency room , where he was taken from the podiatry clinic with complaints of left knee pain. New orders for Tramadol 50 mg and knee brace. R1 has been requesting staff to remove brace. R1 called staff Fucker when he told him the doctors orders to keep it on. -5/21/24 at 12:58 a.m., emergency room report indicated that a CT scan of resident's left leg was performed and returned with a diagnosis of closed nondisplaced fracture of left patella, unspecified fracture morphology, initial encounter, with instructions to follow up with orthopedic surgery. -5/21/24 at 3:55 p.m., R1 yelling for help, called the facility on his cell phone. Nurse went down to check on R1. R1 wanted to be transferred back to bed after maintenance man had put an air mattress on his bed and staff were waiting for it to firm up before he could go back to bed. R1 was upset and called the police. While staff were transferring him back to bed, R1 was talking to 911. Police arrived and talked with R1. -5/22/24 at 12:41 a.m., R1 requesting to be transferred to the emergency room as having chest pain radiating down his right arm, vital signs 96.8, pulse-108, respirations-18, blood pressure 126/85 and oxygen saturation 82-88% on room air. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/22/24 at 1:17 a.m. R1 transferred to emergency room for evaluation per R1's request via ambulance. -5/22/24 at 5:52 a.m., R1 returned from emergency room at this time. New orders for potassium 40 milliequivalents for 4 days and then recheck his potassium level. -5/22/24 at 9:34 p.m., R1 complaining of pain to left chest toward upper left arm. Tramadol given at 4:30 p.m. and was effective. -5/23/24 at 11:19 p.m., R1 screaming that his bottom hurt, R1 wanted some cream for it like lidocaine to make it numb. Nurse explained the medication was not on hand and would need an order for. R1 got upset and yelled at nurse Then send me to the ER. Another nurse went into R1's room and R1 refused, acetaminophen, Tramadol and Biofreeze. -5/24/24 at 2:32 p.m., around 11:45 a.m., R1 told NA that he had called the ambulance, nurse went to R1's room and R1 told nurse that he felt numb on the left side and that it was indicative of a heart attack. R1 left the facility around 1220. -5/24/24 at 9:30 p.m., R1 returned form emergency room around 3:10 p.m. Labs completed there. No new orders. R1 slept most of shift. -5/27/24 at 11:50 a.m., nurse was summoned to R1's room as R1 was attempting to strangle himself with the ties of his hospital gown. R1 kept stating over and over I want to die, please kill me, I want to end my life. Staff removed gown, cords and other things that R1 could harm himself. Put R1 on 15-minute checks and left the room. Nurse went to call the DON and on call physician. While one the phone nurse was called again to R1's room as he was using pillowcase to strangle himself. 911 called. When ambulance arrived, R1 told ambulance staff Do you know what they did to me? They were torturing me. -5/27/24 at 7:30 p.m., R1 was telling male NA a story that he woke up that morning at 9:00 a.m. and was wrapped up tightly in a rug an unable to move. R1's mouth was also covered, preventing him from speaking legibly. R1 could hear the kids in the next room laughing but nobody came to help him. Once he was finally able to speak, he asked for help, but the kids did not come to help him, they just continued to think it was funny. R1 then stated that they told him he used a pillowcase and hospital gown to try and suffocate himself. Stating after that, I would never do that. R1 then stated that he called the ambulance but should have called law enforcement. -5/27/24 at 10:30 p.m., R1 was banging a plastic cup on his bedside table continuously, requesting pain medication. Nurse took pain medication to R1, who then stated that he had requested anxiety medication, clonazepam, and alprazolam. Nurse returned with the alprazolam and acetaminophen and R1 refused both and became angry. Nurse returned to the nurse's station to call DON, when she received a phone call from law enforcement stating R1 called requesting an ambulance to take him to the emergency room . Ambulance arrived and took R1. -5/27/24 at 11:08 p.m., R1 transferred by ambulance per his own request to the emergency room . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/31/24 at 4:14 a.m., R1 was confused and hallucinating. R1 told AN that a woman came into his room and dressed him in women's clothing. R1 asked NA for scissors to cut the fabric off his leg. At 1:00 a.m., R1 told NA that on the other side people are now under water or going to be. R1 asked NA How high is my rank in the US Navy? I am active duty in US Navy right now. -5/31/24 at 3:39 p.m., R1 told staff nurse by calling the facility that he was leaving tonight and asked the nurse for clothes to leave. R1 stated that he already talked with the DON and was going to travel internationally. -5/31/24 at 5:08 p.m., at 7:30 am, RN-B heard R1 calling out from his room. RN-B went to R1's room, and R1 asked if someone was in the next room as they did not acknowledge him calling out. RN-B explained that it was the housekeeper cleaning in the hallway. R1 wanted his head of the bed elevated, his glasses and his cell phone. RN-B gave him all of these and clipped his call light to his blanket at chest level. R1 did not need anything else. RN-B was at the nurse's station to make a call regarding another resident and while she was on the phone a law enforcement officer came to her desk and stated that R1 had called 911 and officer went to R1's room. Once RN-B was done with the phone calls RN-B went to R1's room to see what was needed. RN-B asked R1 if he needed anything and R1 picked up his call light stating I have been pushing this for 30 minutes and no one has come. R1 pointed to the officer and told RN-B to get them a chair. RN-B left room so R1 could talk with the officer. At approximately 7:50 a.m., the officer returned to the nurse's station stating that R1 is reporting staff stealing things from him including his passport. RN-B went to get the bag that she removed from his room on 5/27/24, when R1 attempted to kill himself from the DON's office. RN-B told officer that this is the only thing that she took out of his room and in the bag were medication bottles, and money. RN-B removed the medication bottles, and the officer took the bag to R1 and left the facility. -5/31/24 at 6:30 p.m., R1 left facility AMA after signing AMA paperwork with DON and RN-C. All home medication that R1 brought in were sent home with R1. During an interview on 6/5/24 at 11:13 a.m., NA-C stated that R1 would yell, shout and scream to get staff's attention. R1 would not use his call light, R1 would use cell phone to call nurses station for assistance. Towards the end of R1's stay at the facility he would refuse cares and did not want to get out of bed. R1 would make accusations towards staff, R1 told the ambulance crew, the facility staff were torturing him for hours. On 5/27/24, NA-C found R1 with the ties of his hospital gown pulled tightly around his neck. R1 was alert and his face was purple in color. NA-C immediately called for help by yelling and over the walkie as she attempted to get R1 to let go on the ties. RN-B and an agency nurse came to assist. R1 fought against the staff by holding the ties tighter and telling the staff to Just let me die. Kill me. The staff were able to get the gown away from R1 and removed other items that R1 might use to harm himself and put him on 15-minute checks. All staff left the room and RN-B went to call the physician and director of nursing. NA-C was walking by R1's room [ROOM NUMBER] minutes after leaving room and R1 had his pillowcase around his neck tightly. R1 was alert but face was purple in color. NA-C once again yelled and called for help as she attempted to take the pillowcase away from R1. NA-C stated this time she stayed with R1 until the ambulance arrived. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 10:25 a.m., NP-A, R1's primary care provider for the past eight years, indicated that R1 had a long-standing history of depression and anxiety that would wax and wane with the seasons. R1 was on medications for this, and the facility did not administer the medications as ordered, leading to R1's increase in anxiety and depression. NP-A stated that when R1 had an increase in anxiety, R1 would present with chest pains and shortness of breath. R1 did this and no one addressed his anxiety and depression until too late and R1 attempted two strangulations. During an interview on 6/5/24 at 8:35 a.m., RN-B usually work the other wing but would be floated over to assist on that unit. RN-B stated that R1 would call the facility instead of using his call light. R1 would call out for help. One shift RN-B was attempting to give R1 pain medication per R1's request. RN-B took him Acetaminophen but R1 refused that and told RN-B that he wanted his anxiety medication. RN-B went back to the cart to get the medication and brought back alprazolam but R1 wanted the clonazepam, but there was none in the facility for him. R1 demanded he go to the emergency room . RN-B went to call on-physician, but as she was R1 called the ambulance himself. RN-B stated R1 did this multiple times. RN-B stated on 5/27/24, was called to R1's room on the other unit as he was attempting to strangle himself. RN-B arrived to room and R1 was holding the ties to his gown tightly around his neck and NA-C was attempting to remove them. R1 kept saying Just let me die, Kill me. RN-B and the other staff in the room removed the items from R1's room that he could harm himself with. This included a black duffle type bag that had medications in. Put him on 15-minute checks. RN-B left the room to call on call physician and DON. While she was on the phone with the physician R1 attempted to strangle himself with the pillowcase. RN-B called 911 and R1 then remained under 1:1 supervision until he went to the hospital via ambulance. RN-B further stated on 5/31/24, R1 was yelling from his room before breakfast. She went down to check on him and R1 stated that there were children in the bathroom. RN-B reassured him that there were no children in the bathroom, there was a housekeeper cleaning in the next room and talking to the other resident. RN-B made sure that R1 had his call light pinned to his chest and left the room. RN-B took a call regarding another resident and while she was on the phone a law enforcement officer came to the nursing station asking for R1's room. Officer went down to R1's room with RN-B, where R1 told the officer that RN-B had not been in his room and that staff were stealing his things from him, including his passport. During an interview on 6/5/24 at 9:33 a.m., NA-L stated when R1 first arrived at the facility he would get out of bed but toward the end of his stay R1 refused to get out of bed. Staff would go in and ask to change him and R1 would refuse or become grouchy stated to make it fast. R1 would refuse to use his call light and would call the facility to ask for help. During an interview on 6/5/24 at 4:12 p.m., RN-C stated that R1 could be demanding and impatient. On one occasion RN-C administered R1 tramadol and R1 stated that if it was not working within 30 minutes, he wanted to go to the emergency room and call 911 for transport on per self. Another time R1 wanted lidocaine jelly for his buttocks pain, RN-C obtained the order but there was none in the facility emergency kit and explained this to R1, again R1 called 911 for transport to the hospital. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/24 at 10:23 a.m., R1 stated that one morning as he awoke, he realized that he was restrained and could not move or talk very well as his mouth was partially covered. After working at trying to free himself for about 45 minutes he was able to find a braided piece of material and wrap it around his neck, R1 stated that he did this to scare the staff, not to harm himself. R1 stated it worked as they saw him and then they freed him and helped him. R1 stated that he had been on clonazepam for about [AGE] years, took this medication twice daily. R1 further stated that he would take alprazolam as needed. R1 ended this conversation with I was trying to scare those youngsters and have them free me. I would never hurt myself that way. During an interview on 6/6/24 at 10:58 a.m., social service designee (SSD)-A indicated care plans were completed by herself, ADON and DON. SSD-A would complete her assessments and portions of the care plan of brief interview mental status (BIMS), Patient Health Questionnaire (PHQ-9), vulnerable adult assessment and the trauma assessment. SSD-A would then develop her portion of the care plan from those assessments. SSD-A stated the facility was behind on getting the care plan completed in a timely manner. SSD-A stated that some signs and symptoms of depression could be not getting out of bed, seem more with drawn and increased tiredness. SSD-A stated that these symptoms should be in the care plan under the behavior section. SSD-A further stated that the management staff realized there were problems with R1 and spent time in his room to support him. SSD-A would talk about past coping mechanisms that R1 used but R1 never mentioned his use of psychotropic medications. During an interview of 6/6/24 at 11:39 a.m., assistant director of nursing (ADON) verified care plans for residents in the facility were not current. ADON stated the care plans were the guide for staff to assist the resident with their coping mechanism for anxiety and depression. These should be listed on the care plan. Currently staff are being told word of mouth on how to care for residents. During an interview on 6/6/24 at 12:04 p.m., DON stated it is her expectation if a resident has any psychologic diagnoses, there will be a care plan section completed to address the signs and symptoms that staff should watch for and what staff need to do to keep the resident and other safe. Review of the facility's policy dated 11/30/21, titled Care Plans, Comprehensive Person Centered, indicated: 12. The comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment (MDS).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads Care Center	965 McMillan Street Worthington, MN 56187

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on observation, interview and record review, the facility failed to follow standards practice related to central line dressing change, and following physician's orders for one of one resident (R7) who had a central line. Findings include: R7's quarterly Minimum Data Set, dated dated dated [DATE], indicated R7 had an intact cognition, impairment on both lower extremities. R7 required partial to substantial assistance of one staff for activities of daily living and received intravenous medications (IV). R7's interagency transfer orders dated 4/19/24, indicated peripheral intravascular (IV) cares, transparent dressing over site; change transparent dressing every seven days and when damp, loosened, or visibly soiled. R7's physician orders dated 4/25/24, change [NAME]/PICC dressing once a week or whenever it becomes loose or soiled, every Thursday on the day shift. During an observation on 6/5/24, at 4:27 p.m., R7 had a central line catheter placed in right upper chest and a clear dressing over it dated 5/23/24 and initialed. R7 reported he was supposed to have his central line dressing changed every week, however, staff had not changed his central line dressing for over a week. R7's treatment administration record (TAR) for the month May 2024, identified the physician order that directed [NAME]/PICC dressing to be changed once per week on Thursday's. The TAR indicated R2's dressing change was marked as completed on 5/30/24. According to the TAR, the dressing was changed on 5/23/24 as identified on R7's dressing. During an interview on 6/5/24 at 4:40 p.m., director of nursing (DON), verified the dressing was dated 5/23/24 and the treatment was signed off for 5/30/24 but not completed. DON stated that it was her expectation the treatments are completed per physician order. Review of the facility's policy dated 9/29/2021, titled Dressing, sterile indicated dressing to be done according to the physician's order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on interview and record review the facility failed to ensure a comprehensive behavior/mood assessment was completed after a suicide attempt in the facility to determine level of supervision for 1 of 1 resident (R1) who attempted suicide while in the facility. Findings include: R1 admission minimum data set (MDS) dated [DATE], indicated R1 did not have cognitive impairment, no depression with a patient health questionnaire (PHQ 9) score of 1, no hallucinations, or delusions. R1 had diagnoses of anxiety disorder and depression. R1 required minimal to maximal assist of two staff for most activities of daily living. The MDS indicated R1 received antidepressants and antianxiety medications. R1's care plan dated 4/25/24, had not addressed R1's diagnoses of anxiety and depression or any interventions were identified to assist staff with these potential behaviors. R1's progress notes dated 5/27/24, indicated R1 was found by nursing assistant (NA)-C, with the ties of a hospital gown tied tightly around his neck and was holding them tightly and his face was purple in color. NA-C went to R1 and was trying to get him to release the ties as she called for assistance. Registered nurse (RN)-B came to the room and was assisting NA-C with removing the ties from R1's neck as he continued to hold them. R1 kept saying over and over just let me die and kill me please to staff as they removed the ties from around his neck. RN-B and other staff removed all objects from R1's room that he could harm himself with. RN-B left the room to call director of nursing and the on-call physician and placed R1 on 15-minute checks. While on the phone the nurse was called again to R1's room, he was using pillowcase to strangle himself. 911 was called. When ambulance arrived, R1 told ambulance staff Do you know what they did to me? They were torturing me. R1 was transferred to the emergency room . During an interview on 6/5/24 at 8:35 a.m., RN-B stated she had worked with R1 maybe three times and with each time, R1 seemed to have gotten more confused and delusional with thought process and his thinking. RN-B remembered going to R1's room on 5/27/24, assisting with the removal of the ties of R1's hospital gown. RN-B assessed R1 to be physically stable, removed all items from R1's room he could harm himself with, and went to call director of nursing and on-call physician. RN-B put R1 on 15 minutes checks during this this. During a clarification interview on 6/5/24 at 3:22 p.m., RN-B stated R1 was not left alone when she left his room to make phone calls, NA-C remained in room with R1. RN-B felt staff had removed all items R1 could harm himself with and felt 15-minute checks would have been adequate. On 6/6/24 at 10:58 a.m., RN-B further stated she felt like she followed the facility policy, except for making sure someone stayed with R1 while she contacted the DON and on-call physician. RN-B has not assessed R1 after his first attempt to determine his suicide risk level. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 11:13 a.m., NA-C stated she was the staff person who found R1 with the ties of his gown around his neck, as NA-C was walking by room. R1 was holding the ties tightly and R1's facial color was purple. NA-C ran into the R1's room and called for help immediately as she was attempting to remove the ties from R1's neck. NA-C stated RN-B and other staff persons arrived to assist. After removing all items from R1's room that he could harm himself with and assessed R1. RN-B left the room to call DON and on-call provider. NA-C did not remember if RN-B stated that someone was to stay with R1, but RN-B did say to do 15-minute checks. NA-C was walking by R1's room and R1 had his pillowcase tied around his neck and his face was purple in color. NA-C called for help again to R1's room and staff responded. Once the pillowcase was removed RN-B left the room to call 911 and NA-C stayed with R1 until the ambulance. R1 was then taken to the hospital. During an interview on 6/6/24 at 12:04 p.m., DON stated the RN-B should have made sure R1 was not left alone. It is her expectation all staff are aware if a resident is having self-harming behaviors they are not left alone. Review of facility's policy titled Suicide Threats dated 2/4/2022, indicated the following: 3. A staff member shall remain with the resident until the nurse supervisor/charge nurse arrives to evaluate the resident. 4. After assessing the resident in more detail, the nurse supervisor/charge nurse shall notify the resident's attending physician and responsible party and shall seek further direction from the physician.