STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525282	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads Care Center of Kenosha	8633 32nd Ave Kenosha, WI 53142

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observation, interview, record review, the facility failed to ensure 1 of 1 resident (R3) reviewed for self-administration of medications out of a total sample of 31 had been assessed for self-administration of medications, had a physician's order for the self-administrator, and had care plan interventions identified and implemented related to self-administration of medications. Failure to assess and care plan residents for self-administration of medications increases the potential of medication errors for residents. Findings include: Review of the facility's policy titled, Self-Administration of Medications, revised January 2018, indicated, .In order to maintain the resident's high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the residents and other residents of the facility and there is a prescriber's order to self-administer. Procedures: A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process .C. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition .D. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered . R3 was admitted to the facility on [DATE] with a diagnosis of dementia. R3's quarterly Minimum Data Set (MDS), dated [DATE] indicated the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated the resident was severely cognitively impaired. R3's Physician Orders, dated November 2024 included the following: ~Aspirin 81 milligrams (mg) give one tablet by mouth (PO) daily, ~Calcium antacid tablet chewable 500 mg give one tablet PO daily, (continued on next page)

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.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~Vitamin B-12 oral tablet extended release 1000 micrograms (mcg) PO daily, ~Vitamin D-3 oral tablet 50 mcg PO daily. Review of R3' medical record found no evidence of a physician's order for self-administration of medication; no facility assessment for self administration of medications and no care plan for self-administration of medications. During the initial tour on 11/16/24 at 11:15 AM, a clear medication cup containing one small round yellow pill with the number 5 imprinted on it, two white round pills, two small round pink pills, and one medium sized round light orange pill was noted on R3's overbed table. R3 stated he was unsure where the medications were from or who gave him the medication. During an observation and interview on 11/16/24 at 11:25 AM, CMT C (Certified Medication Tech) confirmed that she gave R3 the medications, and that the medications were still on R3's overbed table. CMT C was unable to identify the medication. During the interview, R3 took the medications. During an interview on 11/16/24 at 12:10 PM, DON B (the Director of Nursing) confirmed that medications should not be left at a resident's bedside unless the resident could self-administer their own medications. DON-B confirmed R3 could not self-administer his own medications.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on observations, interviews, and facility policy review, the facility failed to ensure 6 of 28 resident rooms on 2 of 4 halls had been maintained in a safe and homelike manner. Findings include: Review of facility's policy titled, Safe and Homelike Environment, revised 11/19/24, revealed no procedure for the upkeep of the resident rooms. During an observation and interview on 11/16/24 at 11:00 AM, in room [ROOM NUMBER], an area of unpainted dry wall plaster was noted behind the resident's bed. R37 stated he did not remember how long the unpainted area had been there. He stated he would like the area painted. During an observation on 11/16/24 at 12:45 PM, room [ROOM NUMBER] was noted to have a hole in the wall to the left of the window. The hole was approximately four inches wide by two feet long. CNA F (Certified Nursing Assistant) and CNA G stated they had not noticed the hole in the wall. 26446 An observation and interview on 11/16/24 at 11:32 AM revealed wall damage in resident room [ROOM NUMBER]. There was a large spackled/patched area approximately 12 to 18 inches in circumference directly behind the headboard of bed 451B. The patched area was bumpy and unpainted. A second broken area of the wall was observed to the right side of the bed, near the window. This area was severely damaged, with visibly broken drywall approximately 12 to 18 inches in size. The curtain rod was visibly broken. R22 stated that the wall had been damaged for a long time. An observation on 11/16/24 at 12:05 PM revealed wall damage to the left side of bed 453B. There were long deep grooves visibly marked down the side of the wall, approximately 12 inches in length, at head height. During observations and interviews on 11/19/24 at 6:00 PM, NHA A (Nursing Home Administrator) and Maintenance Director (MntDir) stated they were aware of problems with the condition of the rooms and confirmed the observations as stated above. The MntDir stated he did not have enough time to fix everything. He stated he got notifications from staff on the room walls. He stated there had been no plan for repairs to the rooms.

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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** 25232 Based on observations, interviews, and record review, the facility did not ensure that 13 of 13 residents reviewed for smoking and/or vaping (R2, R3, R299, R36, R299, R14, R37, R34, R31, R32, R22, R31, R150, R38, R149, R43, and R36) and one resident reviewed for transfers (R199) were provided with an environment that was free of accident hazards and/or provided with appropriate supervision. R2 was allowed to vape (use an electronic cigarette) while using oxygen in her room instead of being restricted to designated smoking areas away from oxygen. In addition, the facility allowed charging of the e-cigarette in the resident's room. R3 is severely cognitively impaired. R3 was allowed to smoke without supervision and was allowed to smoke outside of the designated area. There was no safety equipment in the area where R3 was observed smoking. R299 smokes unsupervised. When R299 goes outside, R299 is unable to re-enter the building independently; he must wait for staff to come and let him back inside. Facility failure to ensure residents were provided with appropriate supervision and safety devices while smoking or vaping created a finding of immediate jeopardy that began on [DATE]. NHA A (Nursing Home Administrator), DON B (Director of Nursing), Regional Director of Operations, and Regional Clinical Consultant were notified of the finding on [DATE] at 12:49 PM. The immediate jeopardy was removed on [DATE], however the deficient practice continues at a scope/severity of G (actual harm/isolated) for R199 who was transferred in a Hoyer lift without a second person assisting in the transfer, resulting in a right and left proximal femoral fracture and at severity level 2 (potential for more than minimal harm) for the following examples related to smoking/vaping. R36, R299, R38, R34, and R18 smoke unsupervised and did not smoke in a designated smoking area. The area where the residents smoked did not have safety equipment (aprons, fire extinguisher, and/or fire blanket). Theses failures had the potential to cause serious adverse outcomes including serious injury, serious harm, serious impairment, up to and including death. R299 and R150 did not have an initial smoking assessment completed. R2, R3, R43, R31, R36, R38, R22, R14, R32, and R34 did not have quarterly smoking assessments completed. R150, R38, R2, and R22 did not have care plans developed related to smoking/vaping. R199 was to be transferred using a full body (Hoyer) lift and 2 staff assistance. On [DATE], CNA K (Certified Nursing Assistant) transferred R199 without a second staff person assisting. R199 fell and sustained a right and left proximal femoral fracture. Findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	SMOKING/VAPING Review of the facility's policy titled, Vaping Safety Policy and Procedure, and dated [DATE], indicated, .To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. It is also the objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy. Procedures: 1. Vaping is allowed in facility. 2. A smoking/vaping safety assessment will be completed to determine the level of assistance and supervision needed during vaping, the ability to carry and store vaping materials, in her/his own room. The plan of care shall reflect the results of this assessment. The assessment will be completed upon admission, quarterly and with significant change . Review of the facility's policy titled, Smoking Guidelines, dated ,d+[DATE], indicated, .1. Prior to, or upon admission, residents who smoke shall be informed about any limitations on smoking, including designated smoking areas and the extent to which the facility can accommodate their smoking preferences. 2. Smoking restrictions shall be strictly enforced in all nonsmoking areas . According to Public Safety Network (Agency for Healthcare Quality and Research), .the use of any ignition source in the presence of oxygen is potentially hazardous. This issue was addressed specifically by the British Compressed Gases Association, which stated, Electronic cigarettes are . a potential ignition source and, in the context of oxygen-rich environments, have the same fire risks as traditional cigarettes.(11) This opinion was supported by the Electronic Cigarettes Industry Trade Association, which agreed that in the context of oxygen use, it would be appropriate to describe electronic cigarette use as similarly hazardous to smoking.(11) Furthermore they suggest that if a patient needs oxygen, a nonheated source of nicotine such as NRT be considered . https://psnet.ahrq.gov/web-mm/e-cigarette-explosion-patient-room 1. R2 was readmitted to the facility on [DATE] with diagnoses that included chronic respiratory failure. R2's Smoking Evaluation, dated [DATE] and provided by the facility, indicated, R2 is alert, exhibits safe smoking/vaping awareness .e-cigarette/vape .preferred type: disposable .Oxygen Usage: Is the resident able to remove all oxygen equipment before entering designated smoking areas? Not applicable. Review of R2's clinical record and facility provided documents revealed no further smoking evaluations for the resident. Review of R2's Physician Order, dated [DATE] and located under the Orders tab of the EMR, indicated, . Oxygen (two-four) liters/minute as needed PRN (as needed) for hypoxia . R2's quarterly 'Minimum Data Set (MDS) dated [DATE], indicated R2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R2 was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Care Plan, revised [DATE] indicated, .The resident is a smoker/vapes .Interventions: Assist with transportation to/from smoking area, Instruct resident about smoking/vaping risks and hazards and about smoking cessation aids that are available; Monitor oral hygiene; Notify charge nurse immediately if it is suspected resident has violated facility smoking policy; and The resident can vape unsupervised. There was no documented evidence that the resident's care plan had been revised to include oxygen usage and vaping in her room. During observations on [DATE] at 11:00 AM, 5:00 PM, and 5:45 PM, a No smoking, oxygen in use sign was noted on the resident's door in the right upper corner. R2 was noted to have oxygen being administered via nasal cannula. During an interview on [DATE] at 5:45 PM, R2 stated that she vaped in her bedroom several times a day while wearing oxygen. R2 stated that she kept her e-cigarette in her room. During the interview, the surveyor observed R2 bring her white e-cigarette from under the covers in her left hand while she had oxygen going via nasal cannula. R2 stated that she had never had any burn incidents, and she had been vaping for the past two years. During an interview on [DATE] at 7:39 PM, R2 stated that the e-cigarette was rechargeable, and she charged it with her phone cord. E-cigarettes contain a heating element. Any heat source can cause oxygen to ignite, placing the resident at risk for burns. During an interview on [DATE] at 8:24 PM, DON B (Director of Nursing) stated it was the resident's right to vape in her room because it was important to maintain a homelike environment. During the interview, the surveyor and DON B observed R2 lying in bed, wearing her oxygen nasal cannula. R2 confirmed that she was receiving oxygen. DON B asked R2 if she wore her oxygen while she vaped, and R2 stated, Yes. During an interview on [DATE] at 8:35 PM, DON B stated she educated R2 about vaping with oxygen. DON B stated that she told R2 that she would need to have blood oxygen level taken after her oxygen was removed, and if they determined it was within normal limits, she could proceed with vaping. During an interview on [DATE] at 10:30 AM, DON B stated that R2 did not have oxygen anymore, and her blood oxygen levels were monitored every two hours to make sure they maintained normal levels. DON B stated R2 was allowed to continue to vape in her room and keep her own e-cigarette. DON B stated that if R2 needed her oxygen, then R2 would give her e-cigarette to staff. R2's Care Plan, located under the Care Plan tab of the EMR, revealed no documented evidence R2's care plan was revised to include vaping and oxygen usage. The DON confirmed the care plan had not been revised. During the interview on [DATE] at 11:55 AM, the DON stated that the smoking evaluation should be completed quarterly. She confirmed that there were no aprons, fire blankets, and/or fire extinguishers in the smoking area. The DON stated the electronic medical record was set up so that if you answered a question on the smoking evaluation, then the option for a smoking apron will come up, but the system would not allow a person to further elaborate. The DON stated that there was a fire extinguisher in the front of the building/reception area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on [DATE] at 12:00 PM, R2 was observed in her room with her vape; however, there was no oxygen in her room. 2. R3 was readmitted to the facility on [DATE] with diagnoses that included dementia. R3's Smoking Quarterly Review, dated [DATE] and provided by the facility, indicated, .No change to comprehensive smoking evaluation. Quarterly Planning and Interventions .instruct resident about the facility policy on smoking: locations, times, safety concerns .The resident can smoke unsupervised . Review of R2's clinical record and facility provided documents revealed no further smoking evaluations for the resident. Review of R3's quarterly MDS, dated [DATE] indicated R3 had a BIMS score of four out of 15, which indicated R3 was severely cognitively impaired. During an observation on [DATE] at 10:15 AM, R3 was observed sitting on the bench on the front porch. There was a sign posted in front of him that read, This is Not a Designated Smoking Area. R3's four-wheeled walker was positioned in front of him, and there were no staff members present. R3 was smoking a cigarette that had only one-half inch left to the filter line. Another cigarette, with approximately three quarters inch left, was under his left thigh. R3 removed the cigarette under his left thigh. Surveyor observed that the cigarette had been lit at some point. No burn marks were observed on R3's pants. The unlit cigarette fell to the ground in front of R3 while he still had the lit cigarette in his hand. R3 bent down to get the unlit cigarette, and the lit cigarette was observed to be close to R3's face. R3 placed the unlit cigarette in the storage seat of his walker and continued to smoke the lit cigarette which was close to the filter area. R3 was not wearing a smoking apron. There was no fire blanket, no fire extinguisher, or fireproof ash bucket noted. A regular trash can was observed. During an observation on [DATE] at 10:44 AM, R3 had returned inside the facility. A cigarette lighter was noted under the bench where R3 had been seated. The surveyor requested NHA A to come outside, and when he arrived, he picked up the lighter and stated that he wondered where it came from. Surveyor stated that there was a resident outside smoking a few minutes ago. NHA A stated he was unaware of any resident outside smoking on the front porch. During an interview on [DATE] at 11:28 AM, DON B stated that she would like R3 to smoke in the smoking area but was aware that R3 liked to smoke outside the front of the facility. DON B stated that they tried to redirect him. During the interview with the NHA A and DON B on [DATE] at 11:55 AM, NHA A stated that Life Safety surveyors had never said anything about the facility's smoking area. NHA A stated that the facility had just replaced the canister out in the smoking area with a fire rated canister. NHA A confirmed that there was no fireproof canister in front of the facility for the resident (R3) who smokes there. NHA A stated R3 often smoked by the road and confirmed that he liked to keep his cigarette butts. DON B and NHA A both stated that the bench on the front porch was fire rated and that there was a smoking blanket on the wall somewhere by the front reception area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the interview on [DATE] at 3:55 PM, DON B stated that R3 had been re-evaluated by the social worker and was now deemed to be a supervised smoker. DON B stated that the facility would be keeping his smoking material. DON B indicated that R3's BIMS was completed again and was found to be a 6 out of 15 (still severely impaired). 51678 3. R299 was admitted to the facility on [DATE] with diagnoses that included spina bifida and paraplegia. R299's Care Plan, dated [DATE] revealed a focus area related to the resident smoking. A goal was that the resident would not suffer injury from unsafe smoking/vaping practices. Interventions included helping to and from the designated smoking area. R299's medical record did not contain any smoking assessments since their admission or readmission to the facility. R299's MDS, dated [DATE] revealed R299 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact. During an observation on [DATE] at 5:10 PM, 2 Surveyors, who were in the conference room on the south side of the building, approximately 100 feet from the south door, heard someone banging and yelling at the south door of the building. This door led to the designated resident smoking area, and the door was locked. R299 was the resident banging on the door and yelling. Surveyors noted that the door swung outward towards the smoking area. R299 was seated in his wheelchair with his legs extended out on the pedals. In order for R299 to re-enter the building independently, he would have to put the code in to unlock the door, and then try to re-position his wheelchair so that he could open the door before the code expired. At 5:25 PM, R299 was noted to still outside of the south door and was banging and yelling to come in. Surveyors summoned the Activity Coordinator to come and help him in the building. She went and opened the door at 5:35 pm. R299 had to be instructed to move out of the way as the Activity Coordinator was unable to open the door. The Activity Coordinator brought R299 inside the building at 5:36 pm. He had a blanket around his shoulders. R299 had been attempting to re-enter the building for 26 minutes. Per weather.com, it was 50 degrees outside at 5:36 PM. During an interview on [DATE] at 5:38 PM, R299 was asked if someone had helped him get outside to the smoking area. R299 did not respond to the question. During an interview on [DATE] at 6:00 PM, CNA M (Certified Nursing Assistant) stated he had helped R299 out at 5:24 PM, and someone had brought R299 in at 5:38 pm. CNA M was informed of the surveyors' observations. CNA M maintained his statement that he took R299 out at 5:24 PM. During an observation on [DATE] at 11:00 AM, R299 was outside of the door that led to the smoking area. He was unable to get back in and was observed knocking on the door. A staff member assisted him in getting back into the building. He again had to move away from the door for the staff to help him in the building. He had a blanket draped around his shoulders. R299 was speaking in a loud voice and swearing at the staff. The temperature was 55 degrees Fahrenheit (F), and the wind speed was 11 MPH with gusts to 20 MPH from the WSW per weather.com. The wind chill temperature was noted to be 46 degrees. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:25 PM, DON B confirmed R299 should have been monitored and asked how long he wanted to stay outside. She confirmed he was unable to go out and come back into the building without assistance. Failure to ensure residents were provided needed supervision while smoking or vaping created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The jeopardy was removed on [DATE] when the facility completed the following. 1. The facility updated their policy and procedure to address safety in using e-cigarettes including their use only in designated smoking areas. 2. Assessments were reviewed and updated for all residents known to smoke/vape. 3. Based on the findings of the assessments, care plans were reviewed and updated for all residents known to smoke/vape. Appropriate interventions were put into place to ensure resident safety. 4. All staff were trained on the updated policy and procedure and location of the smoking area prior to beginning their next scheduled shift. The deficient practice continues at a scope/severity of G (actual harm/isolated) for R199 related to transfer and at severity level 2 (potential for more than minimal harm) for the following examples also related to smoking/vaping. 4. During an observation on [DATE] at 9:45 AM, when the survey team arrived at the facility, a plastic outdoor cigarette disposal container was found in the parking lot, approximately 15 feet from the south door of the building. No fire extinguishers, smoking aprons, or fire-proof containers were available. There was no staff supervision. There were signs on the building by the door that read, No Smoking within fifteen feet of the building. Further observations on [DATE] at 1:10 PM, 3:17 PM, 5:10 PM, and 9:15 PM, revealed residents exiting the south door without supervision. The residents would stand by the door and smoke, and others would go out to the cigarette disposal container in the parking lot. R3, R36, R299, R38, R34, and R18 were observed smoking in this area. 5. R14 was readmitted to the facility on [DATE] with diagnoses including diabetes mellitus with diabetic neuropathy, cerebral infarction due to unspecified occlusion or stenosis of basilar artery, and peripheral vascular disease (PVD). Review of R14's facility provided Smoking Evaluation (Comprehensive), dated [DATE], indicated, .R14 alert, oriented .exhibits safe smoking/vaping awareness .e-cigarette/vape .disposable .use a wheelchair .able to move about or remove lit material if it falls on them: yes, does the resident exhibit adequate fine motor skills to safely hold a lighted cigarette? Yes .Is resident free of smoking/e-cigarette/vaping related incidents? Yes . Planning and Interventions .Intervention: The resident can smoke unsupervised . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review revealed no evidence of another quarterly smoking assessment completed after this assessment in [DATE]. Review of R14's clinical record and facility provided documents revealed no further smoking evaluations for the resident. During an observation and interview on [DATE] at 7:39 PM, R14 stated that they vaped outside; however, a rechargeable e-cigarette was observed on her bed. During an interview on [DATE] at 4:55 PM, DON B confirmed that R14's quarterly smoking assessment was late and should have been completed in [DATE]. During an interview on [DATE] at 8:50 AM, NHA A stated that vaping had not been a concern at the facility, but since the summer of 2024, there had been an increase in vaping at the facility. NHA A stated that this had always been a smoking building, and vaping was a new concern due to the younger population that the facility was admitting. 6. R37 was admitted on [DATE] with diagnoses that included chronic lymphocytic leukemia, chronic pain syndrome, adult failure to thrive, muscle spasm, and bipolar disorder. R37 had a Smoking Evaluation completed on [DATE] and [DATE]. The evaluations showed he was alert and oriented, had clear speech, and he used a disposable vaping device. The resident had been free of smoking/e-cigarette/vaping related incidents. Smoking Evaluations had not been completed for the first and second quarters of 2024. A smoking evaluation had not been completed until [DATE], after the beginning of the survey. R37's quarterly MDS, dated [DATE] revealed R37 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact. During an observation and interview on [DATE] at 3:39 PM, R37 was observed in his room. R37 stated he uses a vaping device and kept it in his room with him. He stated he was instructed by NHA A that he should vape in his room rather than outside, as it would be easier for him due to his muscle spasms. He stated he usually only got out of bed in the afternoon. His vaping device was not in sight during the observation. During an interview on [DATE] at 8:30 PM, R37 stated his vaping device was rechargeable and could be disposed of when the nicotine liquid was gone. He stated staff did not supervise him when he used the vaping device, and he had no incidents from using the vaping device in his room. 7. R34 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, anxiety, and post-traumatic stress disorder (PTSD). Smoking Evaluations had been completed for R34 on [DATE], [DATE], and [DATE]. There was no documented evidence of a smoking evaluation for the fourth quarter of 2023 or the second quarter of 2024. It was revealed it had been greater than three months since the last smoking evaluation was completed for R34. R34's Care Plan, revised [DATE] and located under the Care Plan tab of the EMR revealed a focus of R34 being a smoker. It was recorded that the resident was independent with smoking and could smoke independently. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observations on [DATE], [DATE], [DATE], and [DATE], R34 was observed to go outside independently to smoke. He was observed to smoke independently, without supervision. 8. R32 was admitted to the facility on [DATE] with diagnoses that included anxiety and depression. Review of R32's Smoking Assessments, revealed only one smoking assessment, dated [DATE], had been completed for the resident. Review of R32's Care Plan, revealed a smoking focus had not been added to the resident's care plan until [DATE], even though they were admitted on [DATE]. The care plan interventions included instructing the resident about smoking/vaping risks and hazards and about smoking cessation aids that were available, the facility's policy on smoking/vaping, and to notify the charge nurse immediately if it was suspected the resident had violated the facility smoking policy. It was recorded that the resident could smoke unsupervised. R32 was observed smoking on [DATE] at 4:00 PM in the smoking area. 26446 9. R22 was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis, multiple sclerosis, and cerebral infarction. R22's Smoking Assessment, was last completed [DATE]. The most recent assessment was not completed timely. Review of R22's annual MDS, dated [DATE], revealed a BIMS score of 15 out of 15 which indicated no cognitive impairment. R22's Care Plan, last revised [DATE], documented that the resident is a smoker/vaper. The interventions identified the resident as a safe vaper and instructed the resident about the facility policy on smoking/vaping, the locations, times, and safety concerns. During an interview on [DATE] at 7:12 PM, R22 stated that she vaped in her room when she had the money to have staff purchase a vape device for her. She stated she has not had one for a while, since she has not had the money to purchase one. 10. R31 was admitted on [DATE] with diagnoses including diabetes mellitus two, venous insufficiency, and epilepsy. Review of R31's Smoking Quarterly Review, revealed the last assessment was completed [DATE]. R31 was assessed as a safe smoker. The most recent quarterly smoking assessment was not completed timely. Review of R31's quarterly MDS, dated [DATE], revealed a BIMS score of 15 out of 15 which indicated no cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R31's Care Plan, documented that the resident is a smoker. The interventions indicated the resident could smoke unsupervised. A new intervention, initiated [DATE] during the survey, stated to conduct a smoking safety assessment as necessary and to provide appropriate smoking management in accordance with the assessment. 11. R150 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus two, peripheral vascular disease, and hypertension. She was assessed as alert upon admission. R150's Smoking Evaluation, was completed [DATE]. R150 was assessed as a smoker, but not identified as safe or unsafe. Review of R150's Care Plan, was initiated on [DATE] as demonstrates compliance with safe smoking regulations. A baseline care plan was not developed timely. 12. R38 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, hypokalemia, and adult failure to thrive. R38's Care Plan, initiated [DATE], documented that the resident is a smoker. The interventions indicated the resident could smoke unsupervised, to instruct the resident about the facility policy on smoking/vaping locations, times, and safety concerns. The care plan did not identify the resident was a safe smoker until [DATE]. R38's Smoking Quarterly Review the last assessment was completed [DATE]. R38 was assessed as a safe smoker. The most recent quarterly smoking assessment was not completed timely. A delayed smoking assessment was completed [DATE] during the survey. Review of R38's quarterly MDS, dated [DATE], revealed a BIMS score of 15 out of 15 which indicated no cognitive impairment. 13. R149 was admitted to the facility on [DATE] with diagnoses including severe protein-calorie malnutrition, hypertension, and epilepsy. R149's Care Plan, initiated [DATE], documented that the resident is a smoker. The interventions documented to conduct a smoking safety assessment as necessary and to provide appropriate smoking management in accordance with the assessment. It did not document if the resident was a safe or unsafe smoker. R149's Smoking Assessment, revealed the first assessment was completed [DATE]. R149's admission MDS, dated [DATE], revealed a BIMS score of 15 out of 15 which indicated no cognitive impairment. 35690 14. R43 was admitted to the facility on [DATE] with diagnoses that included syncope and nicotine dependence. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R43's quarterly MDS, dated [DATE] revealed R43 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Per the MDS, the resident was independent for all activities of daily living. Review of R43's Care Plan, dated [DATE] revealed, The resident is a smoker. The Care Plan revealed a goal of Resident will not suffer injury from smoking/vaping practices through the review date. Interventions included instructing the resident about smoking and the facility policy. Interventions included, .The resident is able to manage his own smoking materials and smoke unsupervised . Review of R43's Smoking Evaluation, located in the EMR under the Focus tab and dated [DATE], 12 days after admission, revealed R43 did not require supervision for smoking. There was no evidence an evaluation had been completed since that time. On [DATE], during the survey, a Smoking Evaluation was completed for R43 which indicated R43 did not require supervision for smoking. 15. R36 was admitted to the facility on [DATE] with diagnoses that included alcoholic cirrhosis of liver with ascites. Review of R36's Smoking Evaluation, dated [DATE], revealed R36 did not require supervision for smoking. This was the only Smoking Evaluation located in R36's EMR. R36's annual MDS, dated [DATE] revealed R36 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Per the MDS, the resident was independent for all activities of daily living. Review of R36's Care Plan located in the EMR under the Care Plan tab, revealed no care plan related to smoking had been developed for the resident until [DATE], after the beginning of the survey. TRANSFERS R199 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction and vascular dementia. R199's quarterly MDS, dated [DATE] indicated R199 had a BIMS of 13 out of 15, which indicated the resident was cognitively intact. The MDS recorded the resident was dependent on staff for all activities of daily living (ADLs). R199's Care Plan, dated [DATE], indicated, .Transfer: The resident requires Hoyer (mechanical) lift with assist of 2 staff . Review of an investigative file for R199 revealed: A hospital Progress Note, dated [DATE], recorded, .Closed fracture of left distal femur Date Noted: [DATE] Assessment: Patient was accidentally dropped from Hoyer (Mechanical) lift when she suffered subsequent left distal femur fracture .Oblique fracture of proximal right femoral shaft . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A document detailing a phone interview with CNA K, dated [DATE], stated, I had a normal regular day [sic] [DATE] nothing happened out of the ordinary. I washed R199 up at 10:30 AM and then proceeded to transfer her with a full body sling. I transferred her by myself. The resident never fell . I took her to the day room. She ate lunch that I fed her about 1:30 PM. She asked me to lay her down. I took her to her room and laid her down by myself. An undated interview with LPN L recorded, [R199] was stating she was dropped by a black CNA. At that time R199 did not state from [Mechanical Lift]. I assessed ROM (range of motion) but could not complete, c/o (complaints of) pain with movement. Could not visualize any swelling or bruising. MD (Medical Doctor) updated STAT [immediate] Xray ordered. Res (resident) refused Tylenol when asked. Administrator updated immediately. Xray was completed STAT which was within four hours and as soon as results popped up Res sent to ER (emergency room) and MD, POA (power of attorney) updated, POA did not answer. POA called again with no answer. POA called back and info provided. An investigation summary recorded, R199 sustained fractures of bilateral lower extremities that were discovered on [DATE] when she complained of acute left lower extremity pain. R199 is a . female with h/o (history of) CVA (cerebrovascular accident) with right sided hemiplegia, vascular dementia, epilepsy and osteoarthritis. She has a BIMs of 7 with a legal guardian .She has lived at (facility name) since [DATE]. She has been non-weight bearing since prior to her admission. She has not sustained any previous falls while a resident in this facility. R199 reports that she was dropped onto the floor during a full mechanical transfer. There was no reported fall or incident on [DATE] or any day previous to this. Her roommate has provided varying statements that include R199 herself attempting to stand then collapsing and R199 being dropped from the lift during a transfer. Staff interviews have resulted in no conclusive evidence of what event actually occurred. Based on the nature and severity of R199's injuries it is reasonable to assume that something happened during the day shift of [DATE] as the soft tissue swelling and abrupt pain onset are indicative of an acute injury. The nursing assistant who worked with R199 on [DATE] during the day shift was deceptive and dishonest during interviews. She did admit to completing a full mechanical lift without a second person present, violating our resident handling policy .Given R199's history of osteoporosis with previous fractures and hardware infection in left hip and long-standing history of non-weight bearing she was at high risk for fractures involving minimal trauma .The facility took action to identify any other residents who had the potential to be affected by this practice. There is no evidence that any other residents have had injuries as result of this deficient practice. Policies and procedures were reviewed. Education was in [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interviews, and record review, the facility failed to ensure that 1 of 1 resident (R100) reviewed for suprapubic catheters was provided with appropriate care. The facility did not have an indication for the catheter and failed to ensure there were physician orders for catheter care. In addition, the facility failed to ensure that R100's care plan included the appropriate type of catheter, and that the catheter had a privacy bag. Findings include: R100 was admitted to the facility on [DATE]. R100's hospital Medicine Admission History and Physical, dated 11/08/24, included a history of .cystocele (prolapsed bladder) repair .suprapubic catheter, 09/23 . Review of hospital Patient Discharge Summary, dated 11/14/24 indicated, .Presenting for multiple days of progressive altered mental status per patient and family. Initial workup in the emergency department showed .a urinalysis concerning for possible UTI (Urinary Tract Infection) (patient does have a suprapubic catheter) . Urine culture 11/08/24 .candida (a yeast that normally lives in small amounts on the skin, in the mouth, and in the belly), Escherichia coli . R100's Physician Orders, did not contain orders for catheter care. R100's Care Plan, located under the Care Plan tab in the EMR, revised 11/15/24, indicated, .The resident has urinary catheter .Interventions: Catheter: The resident has a Foley catheter. Position catheter bag and tubing below the level of the bladder . There was no documented evidence of catheter care as an intervention. During an observation and interview on 11/16/24 at 11:45 AM, R100 was observed R100 in her wheelchair in her room. Her catheter bag, which had no privacy cover, was facing the door to the hallway. During the interview, R100 was not able to indicate why she had a suprapubic catheter. During observations on 11/17/24 at 10:30 AM and 1:00 PM, R100 was observed sitting up in her wheelchair with the catheter bag in her hands, facing the doorway. There was no privacy cover on the catheter bag. During an interview on 11/18/24 at 7:25 PM, the Director of Nursing (DON) confirmed that when a resident had a catheter, there should be physician orders for catheter care, an indication for the use of the catheter, the resident's care plan should include the appropriate catheter type, and the catheter bag should have a privacy cover. The DON confirmed that R100 did not have an indication for the use of the suprapubic catheter, no physician orders for routine catheter care, and her care plan did not include the appropriate catheter type. At 7:35 PM, the DON confirmed that R100 now had a privacy cover for her catheter bag.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observations, interviews, and record review, the facility failed to ensure that 2 of 4 residents (R42 and R149) reviewed for pain management out of a total sample of 31 received pain medications consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. R42 rated pain at a 6.5 out of 10 and stated that anything over 4 was unacceptable for them. Nursing staff were alerted to R42's request for pain medication at 3:38 PM. R42 did not receive pain medication until 4:15 PM. During that time, R42 verbalized she had pain, and was observed to be moaning and rocking. R149 was experiencing pain rated at an 8 or 9 out of 10. R149 had requested pain medication and it took nursing staff over an hour to respond with the medication. When staff responded with the medication, R149's pain rating had increased to 10 out of 10. Findings include: Review of the facility's policy titled, Management of Pain, dated 10/12/22, indicated, .The purpose of this policy is to accomplish .an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhanced dignity and life involvement .Promptly and accurately assessing and diagnosing pain. Monitoring treatment efficacy and side effects .An immediate care plan will be initiated upon admission for any residents with orders for pain management .Document interventions and responses in the medical record as appropriate (i.e. medication administration record, treatment record, nursing progress notes, etc.) and/or on the pain flow sheet . 1. R42 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease, bacteremia, amputation of 2 left toes, and a wound vacuum to a surgical wound on the left lateral leg. R42's admission MDS (Minimum Data Set) assessment dated [DATE] indicated R42 had a BIMS (Brief Interview for Mental Status) score of 15 out of 15, which indicated the resident was cognitively intact. It was recorded that the resident received an opioid medication. R42's Physician Orders, dated 10/29/24, revealed R42 was to receive Oxycodone HCl (hydrochloride) Oral Tablet 5 mg, 1 tablet by mouth every 8 hours as needed for pain management. R42's Care Plan last revised 10/31/24, revealed R42 had complained of pain related to surgical wounds, amputation of two left toes, and a vascular graft infection. Interventions included administering medications for pain as ordered, to monitor/record pain characteristics, and to monitor/record/report to nurse resident complaints of pain or requests for pain treatment. R42's MAR (Medication Administration Record) indicated that R42 received oxycodone last on 11/15/24 at 3:35 PM for a pain level of 8. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/16/24 from 3:38 PM through 4:11 PM, Surveyor conducted a continuous observation and interviewed R42. At 3:38 PM, R42 stated she had asked a staff member for pain medication 5 minutes ago. She stated that the staff member had told her she would go tell the nurse. R42 stated that her current pain was a 6.5 out of 10 (with 0 being no pain and 10 being the worst pain experienced). R42 confirmed that any pain above a 4 was too much for her. She stated she would wait for the nurse. The resident was visibly moaning, rocking, and expressing she had pain in the left leg wound vacuum location. During this same time, Surveyor was also able to observe LPN H (Licensed Practical Nurse). From 3:40 PM until 4:00 PM LPN H was at nurses' station and speaking with coworkers. At 4:00 PM, R42 told Surveyor that no one had brought her pain medication. At 4:00 PM, LPN H was observed at her medication cart, pushing it down the 400 hall. LPN H stopped at 2 other resident rooms and administered medications to those 2 residents. At 4:11 PM, LPN H was observed placing the medication cart near R42's room. LPN H entered R42's and asked the resident about her pain level. R42 stated her pain was a 6.5 out of 10. LPN H exited the resident's room and stated to the Surveyor R42 was receiving an as needed pain medication. LPN H confirmed that she was notified earlier that R42 was in pain and needed medication. LPN H stated she had been busy getting medication counted and prepared. Review of R42's MAR, had received her dose of Oxycodone HCl on 11/16/24 at 4:15 PM. LPN H documented R42's pain was 5 out of 10 even though R42 had reported it to be 6.5 out of 10. Review of the MAR found that timing was not an issue as this was the first time R42 had received pain medication since 11/15/24 at 3:35 PM. During an interview on 11/19/24 at 2:45 PM, DON B (Director of Nursing) stated that if a resident had expressed pain, she expected the nurse to not delay in providing the medication. She confirmed that if a resident stated her pain was at a 6, the nurse needed to take care of it right away. She stated it was not acceptable to delay and was not aware that LPN H had documented an incorrect pain level. DON B was aware R42 had ongoing concerns with pain due to her leg wound. During an interview on 11/19/24 at 4:27 PM, CMT I (Certified Medication Technician) stated she was familiar with R42. She stated that if a resident or staff member tells her that a resident is having pain, she will go get the nurse to get pain medication if it is not available on the medication cart. She stated that she was aware that R42 had pain and could let staff know when they needed pain medication. CMT I said it was important to give residents their pain medication as soon as they were made aware. LPN H was not available for additional interviews. 2. R149 was admitted to the facility on [DATE] with diagnoses including wound vacuum to abdominal surgical wound. R149's MDS, dated [DATE] indicated R149 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R149's Care Plan, last revised 11/13/24, revealed that the resident was at risk for pain related to a surgical wound. The interventions identified included administering pain medications as ordered, to monitor/record/report to the nurse the resident's complaints of pain or requests for pain treatment, and to monitor/record pain characteristics. R149's Physician Orders dated 11/12/24, indicated R149 was to receive oxycodone HCl, Oral Tablet 10 milligrams (mg), 1 tablet by mouth every four hours as needed for pain. During an interview on 11/16/24 at 5:19 PM, R149 stated that she currently had an abdominal wound vacuum for the healing of a surgical wound. She stated that when she asked for pain medication, the staff would sometimes not return for 30 minutes or longer. R149 stated staff just don't come back. She stated that her pain was often 8 or 9 out of 10, and she needed pain medication. During an interview on 11/18/24 at 1:45 PM, R149 stated she had requested a pain pill an hour ago from RN J, but RN J had not returned. R149's MAR indicated the last time R149 had Oxycodone HCl on 11/18/24 at 8:18 AM, more than 5 hours earlier. R149's order is for 1 tablet every four hours as needed. It was recorded that the resident's pain had been at 9 out of 10 and the medication had been effective. During an interview 11/18/24 at 2:03 PM, RN E stated that RN J had gone to the secure memory unit to provide one-on-one supervision for a resident. RN E stated that RN J was not currently providing medication administration from her medication cart. RN E reviewed the medication administration for R149 and confirmed that the resident had not received a pain pill since approximately 8:30 AM. RN E stated she would go speak with the resident. RN E stated that although RN J was the nurse providing medication for the 4 hall, staff had to take turns monitoring a specific resident on the secured unit for approximately an hour. R149's MAR revealed RN E administered a dose of Oxycodone HCl on 11/18/24 at 2:06 PM, nearly 2 hours after R149 had requested pain medication. It was recorded that the resident had rated her pain at 10 out of 10, which is higher than the original rating of 9, and the medication had been effective. During an interview on 11/18/24 at 2:35 PM, RN J stated that R149 had told her that she needed pain medication because she was actively in pain. She stated she was sorry, and that she had forgotten. RN J stated that she had been assigned to go to the secured unit to do one-to-one supervision for a resident from 1:30 PM to 2:00 PM. She stated that all staff, including staff working on the medication carts, might get assigned to go and do monitoring on the secured unit for the resident requiring one-on-one supervision. RN J stated that she had been scheduled for monitoring around the time she would be doing her second medication pass for residents. She confirmed that being assigned to provide one-on-one supervision on the secured unit had disrupted her second medication pass, and because of it, she had forgotten to give R149 the pain medication. She stated it was frustrating that it was at the time she needed to pass medications. During an interview on 11/19/24 at 4:59 PM, DON B stated that it was important to ensure residents received pain medication. She stated that resident safety was important, but so was pain management. DON B stated she was not aware there had been a delay in R149 receiving her pain medication, and that could exacerbate other conditions that they have.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on observation, record review, and interview, the facility did not ensure that staff accurately administered medications for 1 of 31 sampled residents (R9). CMT M (Certified Medication Tech) did not mix compounded insulin for R9 prior to administering it. Failure to do so could result in an inaccurate proportion of short or long acting insulin being given. Findings include: Review of the Novolog 70/30 manufacturer's instructions, provided by the facility, revealed 70/30 insulin was a .mixture of 70% intermediate-acting insulin (isophane) and 30% short-acting insulin (regular). Before using, gently roll the vial or cartridge, turning it upside down and back 10 times to mix the medication. Do not shake the container . Review of the facility's undated policy titled, Registered Nurse (RN) Delegating Tasks to Medication Aides stated, .the responsibility and authority to decide what the aide can and cannot do. The RN may decide to delegate a task that was not taught to the aide (insulin injections, for example). If so, the RN must ensure the medication aide is trained, competent, and supported whenever they need help . R9 was readmitted to the facility on [DATE] with diagnoses that included diabetes mellitus. During an observation on 11/17/24 at 5:00 PM, CMT M prepared R9's insulin. She retrieved R9's Novolog 70/30 insulin from the medication cart. She sanitized the top of the vial, then drew up 35 units into the syringe, and injected the insulin into R9's right arm. She had not mixed the insulin prior to drawing up the insulin to R9. During an interview on 11/17/24 at 5:20 PM CMT M confirmed she had not mixed the 70/30 insulin. She stated she was not aware she should have mixed the insulin. Review of CMT M's Insulin Competency Checklist dated 07/11/24 and provided by the facility, revealed she had been marked as satisfactorily performing the task of insulin administration. The competency had included how to prepare any type of cloudy insulin prior to administration. During an interview on 11/17/24 at 6:00 PM, DON B (Director of Nursing) confirmed the 70/30 insulin vial should have been gently rolled to mix the two types of insulin. She stated if the 70/30 insulin was not mixed, the resident would not have received the correct dosage of either type of insulin, and that could have affected R9's blood glucose levels. During an interview on 11/19/24 at 10:04 AM with RN N (Registered Nurse) on the correct way to prepare 70/30 insulin, she stated the insulin vial would have to be rolled several times to mix the two types of insulin together.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525282	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads Care Center of Kenosha	8633 32nd Ave Kenosha, WI 53142

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observations, interviews, and facility policy review, the facility failed to ensure food was properly labeled and dated as to when they expired, and all expired foods were disposed of in accordance with professional standards for food service safety as required for 51 census residents who received meals from the facility kitchen. These failures had the potential to lead to food-borne illness among all facility residents. Findings include: Review of a facility's policy titled, Food Storage, dated [DATE], revealed Food will be purchased in quantities that can be stored properly, and arranged in food groups for organized storage and inventory .Old stock is always used first .Food should be dated as it is placed on the shelves .Date marking will be visible on all high-risk food to indicate the date by which a ready-to-eat .All containers must be legible and accurately labeled and dated. During an initial kitchen observation with DA O (Dietary Aide) and DM P (Dietary Manager) on [DATE] from 10:29 AM to 10:50 AM, it was revealed: -The walk-in refrigerator had six one-quart cartons of heavy whipping cream. The best by dates were [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. DA O stated that the dietary staff tried to keep track of the use by dates in the refrigerator, confirmed the expired dates on the cartons, and stated they would be discarded. -The food preparation area had three large plastic containers. One container for breadcrumbs had posted dates of [DATE], with a use by date of [DATE]. The second container for oatmeal, had posted dates of [DATE], with a use by date of [DATE]. The third container for rice had posted dates of [DATE], with a use by date of [DATE]. DM P stated that he believed the posted dates were wrong but could not be sure when they were put in the three food containers. -Underneath the food preparation table contained a 25 lb. (pound) container of Ready Care Instant Food Thickener. It was opened and uncovered, with ,d+[DATE] dated on it. The DM stated that the facility had not used the thickening powder for a long time, and it needed to be thrown away. During an additional kitchen observation with DM P on [DATE] at 10:54 AM, it was revealed: -The walk-in refrigerator contained a box of approximately ,d+[DATE]oz (ounce) Ready Care Strawberry Shakes, thawed. The box documented to Keep Frozen. The cartons instructed to Use within 14 days after thawing. There was no observable thaw date marked on the shakes. DM P stated that he was not aware of the requirements to ensure shakes were dated when thawed. -The walk-in refrigerator had an opened one-quart Ready Care Thickened Dairy Drink, dated ,d+[DATE] and , d+[DATE] with a best by date of [DATE].A second one-quart Ready Care Thickened Dairy Drink, was dated , d+[DATE] with a best by date of [DATE]. The cartons instructed After opening, may be kept up to 7 days under refrigeration. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Additionally, the walk-in refrigerator had one opened 46 oz. Ready Care Thickened Apple Juice with , d+[DATE] and ,d+[DATE] written on the carton. A second opened 46 oz. Ready Care Thickened Golden Fruit Punch with ,d+[DATE] and ,d+[DATE] written on it. The carton instructed After opening, may be kept up to 7 days under refrigeration. DM P stated that he was not aware of the special requirements for opening and dating thickened drinks and disposed of the opened drinks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on observations, interview, record review, and facility policy review, the facility failed to complete catheter care, wound care, and/or medication administration in a manner to prevent cross contamination for 2 of 31 sampled residents (R35 and R100) on 4 separate occasions. Findings include: Review of the facility's policy titled, Hand Hygiene/Handwashing, dated 05/17/22, revealed no information related to when to don and doff gloves. The policy did state to perform hand hygiene after removing gloves. Review of the facility's policy titled, Dressing Change-(Clean/Non-Sterile, dated 05/17/22, revealed, .Bring supplies into resident's room. Individual resident supplies may be placed on the over bed table after it has been disinfected and/or a protective barrier placed on the table .Prepare/open any necessary supplies and place on top of clean barrier . 1. R35 was readmitted to the facility on [DATE] with diagnoses that included traumatic brain injury. R35's Care Plan dated 09/19/24 revealed a focus area for enhanced barrier precautions (EBP) related to the resident previously having the organism Providencia Rettgeri (a contagious organism found in the urinary and gastrointestinal tracts) in her urine. Interventions included the implementation of EBP, instruct caregivers to wear disposable gowns and gloves during physical contact with the resident, and provide a sign on the resident's door to warn visitors and staff. During an observation on 11/16/24 at 12:45 PM, a sign was noted on the outside of R35's room that revealed EBP was to be used with any care that would expose the care giver to an infectious bodily fluid. The sign recorded to wear a gown and gloves if providing personal care. CNA F and CNA G (Certified Nursing Assistant) provided personal care to R35. They did not wear gowns. CNA F had completed the perineal care, assisted with changing a soiled brief, and held soiled linens against her uniform. During an interview on 11/16/24 at 1:08 PM, CNA F and CNA G confirmed they had not donned a barrier gown prior to providing personal care to R35. They stated they were aware R35 had EBP in place. 2. R100 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, anemia, and systemic lupus erythematosus (SLE). R100's hospital History and Physical dated 11/08/24, R100 had a suprapubic catheter due to a prolapsed bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/17/24 at 2:45 PM, CNA D provided suprapubic catheter care for R100. CNA D washed his hands and put on gloves. He washed the suprapubic tubing with a soapy washcloth and then wiped the soap off the catheter tubing with a new wet washcloth. With the same gloves on, he used the bed control to raise the head and foot of the bed, moved the overbed table, and pulled the privacy curtain back. He then removed his gown and gloves and washed his hands. He gathered the soiled towels and carried them down the hall to the tub room. He held those soiled towels against the front of his uniform. He sanitized his hands after putting the towels in the soiled laundry container. During an interview on 11/17/24 at 2:50 PM CNA D confirmed the above observation. He confirmed touching surfaces with his soiled gloves and holding the contaminated towels against his uniform could have contaminated them with infectious organisms. 3. During an observation of a wound dressing change for R100 on 11/17/24 at 2:55 PM, RN E placed a box of gloves on the resident's overbed table, moved the table closer to the bed, and then placed dressing supplies on top of the table. RN E did not sanitize the overbed tab or use a barrier prior to placing the supplies on the table. During an interview on 11/17/24 at 3:10 PM, RN E confirmed she should have sanitized the top of the overbed table or placed a barrier down to set-up for the dressing change. 4. During an observation on 11/19/24 at 10:04 AM, RN N was observed dispensing medications for R9. RN N did not perform hand hygiene, and she did not wear gloves. While dispensing the medications, RN N took tablets out of each of the bottles with her fingers. During an interview on 11/19/24 at 10:20 AM, RN N confirmed she had used her fingers to take the tablets out of the medication bottles. She confirmed she had not performed hand hygiene prior to beginning. RN N confirmed she had touched many surfaces prior to touching the tablets and that the tablets were now contaminated. During an interview on 11/19/24 at 11:28 AM, DON B (Director of Nursing) confirmed that CNA D, CNA F, CNAG, RN E, and RN N had not used proper infection control procedures. Their failures put other residents at risk of getting infections due to cross contamination. DON B was asked to provide a policy on EBP. None was provided by the end of the survey.