STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525315	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads Care Center of Weyauwega	717 E Alfred St Weyauwega, WI 54983

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793 Based on staff interview and record review, the facility did not ensure appropriate care and treatment was provided consistent with N6 Wisconsin Nurse Practice Act when 1 resident (R) (R2) of 9 sampled residents experienced a change of condition. On 5/16/24, R2 experienced a change of condition and indicated to staff that R2 was having difficulty breathing and felt like R2 was having a stroke. Certified Nursing Assistant (CNA)-D and CNA-J reported R2's change of condition to nursing staff on 5/16/24. Registered Nurse (RN)-C and Licensed Practical Nurse (LPN)-K did not adequately assess R2 or report R2's concerns to a physician. In addition, R2's change of condition was not reported to night shift staff on 5/16/24. On 5/17/24 at approximately 5:45 AM, R2 passed away at the facility due to diastolic congestive heart failure (left-sided heart failure that causes symptoms that include difficulty breathing, dizziness, fatigue, increased urination, and confusion). The facility's failure to adequately assess, monitor, and notify a physician for a resident who reported difficulty breathing and felt like they were having a stroke created a finding of immediate jeopardy that began on 5/16/24. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 7/17/24 at 3:44 PM. The immediate jeopardy was removed on 7/17/24; however, the deficient practice continues at a scope/severity level D (potential for harm/isolated) as the facility continues to implement an action plan. Findings include: The facility's Physician and Family Notification-Change in Condition policy, revised 5/1/24, states the facility will inform the resident, consult with the resident's physician or nurse practitioner, and notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). According to the Wisconsin Nurse Practice Act, N6.03(1), A RN shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to LPN's or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the LPN shall, under the general supervision of an RN or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an RN provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. From 7/16/24 to 7/17/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including osteomyelitis (bone infection) of the right foot, chronic respiratory failure, history of stroke, hypertension (high blood pressure), dysphasia (difficulty swallowing), and anxiety. R2's most recent Minimum Data Set (MDS) assessment, dated 3/4/24, stated R2 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 had intact cognition. The MDS assessment also indicated R2 was independent with set-up assistance for activities of daily living (ADLs) such as transferring and toileting. R2's care plan, initiated on 1/26/24, stated to monitor and document R2's respiratory rate, depth, and quality each shift or as ordered. R2's care plan also stated R2's anxiety increased when R2 was unable to get out all secretions from R2's trach. R2's last documented vital signs were on 5/15/24 at 7:04 PM and indicated the following: ~ Pulse: 54 beats per minute ~ Blood pressure: 128/54 mmHg (millimeters of mercury) ~ Oxygen saturation: 96% (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ Respiratory rate: 22 breaths per minute ~ Temperature: 97.6 degrees Fahrenheit (F) R2's medical record did not contain any vital signs or assessments after 5/15/24 at 7:04 PM. A progress note, dated 5/15/24 at 6:08 PM, indicated Nurse Practitioner (NP) was aware of R2's weight loss and ordered Med pass TID (three times per day). R2's medical record did not contain any progress notes on 5/16/24. A progress note, dated 5/17/24 at 2:30 AM, indicated R2 was awake in bed at approximately 12:30 AM and voiced no complaints of pain or discomfort at that time. R2's lung sounds were clear. (The progress note was entered on 5/17/24 at 8:31 AM by Registered Nurse (RN)-G after R2 passed away.) A progress note, dated 5/17/24 at 4:30 AM, indicated R2 was sleeping well with no complaints of shortness of breath or dyspnea. R2 was awake earlier on the night shift. No signs of increased restlessness were noted. (The progress note was entered on 5/17/24 at 6:31 AM by RN-G after R2 passed away.) A progress note, dated 5/17/24 at 6:32 AM, indicated R2 had no pulse, respirations, or audible heart tones. RN-G entered R2's room to administer R2's scheduled medication and noted R2 was unresponsive with no respirations or heartbeat noted upon auscultation and no pupillary response to light. R2's time of death was pronounced as 5:45 AM. On 7/16/24 at 1:15 PM, Surveyor interviewed CNA-D who stated CNA-D had taken care of R2 for a long time and knew R2 well. CNA-D stated CNA-D worked the AM shift on 5/16/24 and noticed R2's call light was on at the start of the shift. CNA-D answered R2's call light and noted R2 was incontinent which was unusual for R2. While CNA-D assisted R2 with cares, R2 mouthed, I can't breathe. CNA-D stated R2 was grabbing at CNA-D while repeating, I can't breathe. CNA-D also stated R2 was weaker, required more assistance with cares than usual, and looked pale. CNA-D reported the concerns to RN-C multiple times during the AM shift and reported the concerns to CNA-J on the PM shift. CNA-D indicated that was not the first time CNA-D thought RN-C did not respond appropriately to a resident's change of condition. CNA-D reported the concerns to management and was told to document the concerns in R2's medical record. On 7/17/24 at 8:45 AM, Surveyor interviewed RN-C who could not recall if RN-C assessed R2 related to a change of condition during the AM shift on 5/16/24. RN-C stated RN-C reviewed R2's vital signs and they were normal. RN-C could not recall which vital signs had been obtained or what the results were. RN-C stated it was normal for R2 to mouth that R2 couldn't breathe. On 7/17/24 at 8:58 AM, Surveyor interviewed RN-G who did not recall anything in report from the PM shift about R2's change of condition. RN-G could not remember specifics but stated RN-G did not recall doing any assessments on R2 during the night and wasn't aware of any concerns. On 7/17/24 at 9:11 AM, Surveyor interviewed CNA-F who stated R2 had less energy, needed more help with cares and transfers, and was more confused than usual on the 5/16/24 AM shift. CNA-F stated CNA-F did not report the concerns to anyone because RN-C was already aware. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/17/24 at 10:30 AM, Surveyor interviewed RN-H who completed wound rounds for R2 on the 5/16/24 AM shift. RN-H stated R2 did not look like R2's self. RN-H indicated R2 was not as talkative, was more lethargic looking, and was more gray than usual. RN-H knew that RN-C had been informed of the changes but was unsure if there was any follow-up completed. On 7/17/24 at 10:35 AM, Surveyor interviewed CNA-J who stated CNA-J was told in report by CNA-E about R2's concerns from the AM shift. CNA-J checked on R2 early in the shift due to the concerns and stated R2 mouthed to CNA-J that R2 felt like R2 was having a stroke and didn't feel well. CNA-J reported the information to LPN-K. CNA-J stated LPN-K did vital signs, however, LPN-K could not recall which vital signs had been checked or what the results were. CNA-J stated R2 was routinely anxious and some staff did not take R2's concerns seriously because of it. On 7/17/24 at 10:51 AM, Surveyor interviewed LPN-K who verified CNA-J reported concerns about R2. LPN-K stated LPN-K went to see R2 but could not recall what type of assessment had been completed or if the assessment was documented. LPN-K checked R2's oxygen saturation and stated it was normal, however, LPN-K could not recall the exact value. LPN-K also placed a humidifier on R2's trach collar. On 7/17/24 at 11:32 AM, Surveyor interviewed Medical Examiner (ME)-P who verified R2's cause of death was documented as diastolic congestive heart failure. On 7/17/24 at 11:45 AM, Surveyor interviewed CNA-I who stated CNA-I did not work with R2 in the days prior to R2's passing and indicated RN-C was not good at responding to CNA or resident concerns. CNA-I recalled an instance in which CNA-I reported to RN-C that R2 had difficulty breathing and clearing secretions. RN-C told CNA-I to tell R2 to suction R2's self and did not assess R2. On 7/17/24 at 11:53 AM, Surveyor interviewed CNA-M who assisted CNA-E with R2's cares on 5/16/24 which was unusual because R2 was fairly independent with ADLs. CNA-M verified R2 mouthed that R2 could not breathe and looked more pale than usual. CNA-M stated R2 came out of R2's room a lot to look for staff and seemed anxious and confused. CNA-M stated RN-C was not always responsive to resident changes. On 7/17/24 at 12:25 PM, Surveyor interviewed Nurse Practitioner (NP)-O was who not working during R2's change of condition but was familiar with R2. NP-O stated R2 was sick overall and NP-O last saw R2 on 5/13/24 with no concerns. NP-O verified NP-O wanted to be notified if a resident voiced concerns that they couldn't breathe and felt like they were having a stroke. On 7/17/24 at 12:29 PM, Surveyor interviewed CNA-N who worked the 5/16/24 night shift but was not assigned to R2's unit. CNA-N stated CNA-J said in report that R2 was more anxious than usual and that CNA-E had concerns about R2 being able to breathe. CNA-N stated R2 used R2's call light more than usual during the night which was unusual because R2 was fairly independent. CNA-N indicated RN-C did not respond to CNA concerns regarding residents and changes of condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/17/24 at 12:50 PM, Surveyor interviewed NHA-A and Director of Nursing (DON)-B regarding R2's change of condition. DON-B stated DON-B expects nursing staff to document assessments in the medical record and report back to CNA staff regarding the concerns. DON-B stated RN-C had been verbally reprimanded in the past regarding documenting assessments and was recently written up for the same concern for a different resident. DON-B verified if a resident or a CNA on behalf of a resident reported breathing concerns, nursing staff should do a full respiratory assessment including a check of the resident's oxygen saturation, respiratory rate, and lung sounds. DON-B also verified if a resident or a CNA on behalf of a resident reported stroke concerns, nursing staff should notify the physician or NP due to timeframes for stroke medications that could be administered. DON-B stated nursing staff should also assess a resident's neurological status including vital signs, responsiveness, orientation, hand grasps, and facial droop. On 7/17/24 at 2:58 PM, Surveyor interviewed Family Member (FM)-Q regarding R2's change of condition. FM-Q verified FM-Q was not notified of any concerns for R2 on 5/16/24 and was notified on 5/17/24 that R2 passed away. FM-Q stated R2 had a lot of paranoia and anxiety about dying. The failure to assess, monitor, and notify a provider for a resident who reported breathing and stroke concerns led to serious harm for R2 which created a finding of Immediate Jeopardy. The facility removed the jeopardy on 7/17/24 when it had completed the following: 1. Educated nursing staff on change of condition policies and procedures, how to conduct a physical head-to-toe assessment, completing change of condition documentation, family and provider notification, and a change of condition form. One-to-one education was completed with nurses who were directly involved. 2. Initiated daily monitoring of nursing and CNA shift-to-shift reports. 3. Completed a change of condition audit and initiated daily shift change audits. 4. Held a quality assurance performance improvement (QAPI) meeting with the Medical Director to discuss the event and corrective measures to be taken.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793 Based on staff interview and record review, the facility did not ensure competent staff completed nail care for 1 resident (R) (R3) of 9 sampled residents. In addition, the facility did not ensure competent staff completed vital signs which had the potential to affect multiple residents residing in the facility. Hospitality Aide (HA)-E was asked to complete nail care for R3 under the direction of Registered Nurse (RN)-C. HA-E and HA-L were asked to complete vital signs for multiple residents by RN-C. HA-E and HA-L were not enrolled in a Certified Nursing Assistant (CNA) course. Findings include: The Department of Health Services (DHS) memo P-01559 titled Role of Non-Certified Staff in Provision of Care, dated November 2021, states in 2000, the Department approved the following list of tasks that an individual can perform without being listed on the Wisconsin Nurse Aide Registry as a nurse aide to assist long-term care facilities with the implementation of helpersor hospitality aides and to ensure the facility remains in compliance with the nurse aide training requirements. An individual performing the following non-direct care tasks does not need to be a certified nurse aide: Resident Rooms: ~ Make unoccupied beds ~ Perform non-direct care tasks - no physical contact with the resident is allowed ~ Assist residents in fastening outer garments (buttons, zippers, belts) ~ Help residents prepare toiletries such as toothbrush and tooth paste ~ Fold and put away clean laundry ~ Stock supplies to resident rooms or nurse servers ~ Put away resident laundry ~ Assist in straightening room, bedside stand, closet, and/or drawers ~ Refill toilet paper, paper towel, hand sanitizer and soap dispensers ~ Assist resident and/or maintain room in a neat, clean and safe condition ~ Assist caregivers in obtaining necessary supplies (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Pass water to residents capable of having water at bedside ~ Deliver mail to residents and assist in opening, as appropriate Dining Areas: ~ Distribute linens and set tables prior to meals ~ Assist with meal selections, set up trays for independent residents; open milk, tableware, place clothing protectors, napkins ~ Pass warm washcloths to residents for freshening of hands and face before and after meals - no assistance with washing the resident's face or hands is allowed ~ Pick up trays and food items from dining areas and return to carts - may not calculate or document percentage of intake ~ Provide general clean-up during mealtime ~ Fill water pitchers Activity Areas: ~ Assemble activity equipment ~ Assist with activity set up and take down ~ Assist activity staff with activity, but not cares ~ Assist in construction of bulletin board displays of upcoming activities ~ Tune radios and televisions to resident preferred programs ~ Clean and/or straighten areas before and after activity ~ Assist individual residents in accomplishing an activity ~ Assist with writing cards and letters, telephone calls, sending emails, virtual calls (zoom, skype, etc.) ~ Assist with using the computer to play games, search the Internet, email, etc. ~ Read to residents Common Unit Areas: ~ Answer phones and emails (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Greet and direct visitors ~ Maintain nursing unit and patient areas in neat manner ~ Stock supply areas with PPE, incontinent products, etc. if applicable (storage area to unit area) ~ Greet, screen visitors, staff and others that come into the building. ~ Identify unsafe situations, unusual occurrences, or changes in resident abilities, and advise professional staff of same ~ Visit with residents Non-certified staff may also work as a transporter (pushing residents from point A to point B, but may not transfer to and from wheelchairs). 1. From 7/16/24 to 7/17/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including history of aneurysm, anxiety, malnutrition, depression, and dementia. R3's most recent Minimum Data Set (MDS) assessment, dated 5/7/24, stated R3's Brief Interview for Mental Status (BIMS) score was 13 out of 15 which indicated R3 had intact cognition. R3 was prescribed warfarin sodium 3 mg (milligrams) (an anticoagulant medication). On 7/16/24 at 12:55 PM, Surveyor interviewed HA-E regarding HA-E's job duties. HA-E verified HA-E trimmed R3's nails after being asked to do so by RN-C. HA-E stated after someone asked HA-E if HA-E was qualified to do that, HA-E did not trim any other resident's nails. On 7/17/24 at 12:50 PM, Surveyor interviewed Director of Nursing (DON)-B who verified HAs are not supposed to trim resident's nails. 2. On 7/16/24 at 12:55 PM, Surveyor interviewed HA-E regarding completing residents' vital signs. HA-E stated only RN-C had asked HA-E to take vital signs which confused HA-E because HA-E thought HA-E was not supposed to take vital signs. HA-E verified HA-E had not had any CNA training when asked to take resident's vital signs. On 7/16/24 at 1:15 PM, Surveyor interviewed CNA-D regarding the delegation of vital signs from nursing staff. CNA-D stated RN-C always asked CNAs to obtain vital signs for RN-C's unit, including change of condition and medication vital signs. On 7/17/24 at 8:45 AM, Surveyor interviewed RN-C regarding delegating vital signs to CNA and HA staff. RN-C stated some HAs were trained to take vital signs and CNAs were able to take vital signs as well. RN-C stated if a resident had a change of condition or if the vital signs were related to medication administration, the nurse would obtain those vital signs. On 7/17/24 at 10:30 AM, Surveyor interviewed RN-H regarding delegating vital signs to CNA and HA staff. RN-H stated HA staff are not to take vital signs and CNA staff are to take regular/weekly vital signs on shower days. RN-H stated nursing staff should obtain all other vital signs as part of their assessments. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 11:45 AM, Surveyor interviewed CNA-I regarding delegation of vital signs from nursing staff. CNA-I stated only RN-C asked CNA staff to complete most or all vital signs on their assigned unit, including medication vital signs. CNA-I stated the facility had a recent meeting regarding what vital signs CNA staff should obtain and it was verified that CNA staff should only completed weekly shower vital signs. CNA-I indicated HA staff should not complete hands on care or take vital signs. On 7/17/24 at 11:41 AM, Surveyor interviewed HA-L regarding HA-L's job duties. HA-L stated HA-L's job was to assist residents with whatever they needed help with, including making beds, passing water, and answering call lights. HA-L verified HA-L was asked by RN-C to obtain vital signs. HA-L stated HA-L was shown how to obtain vital signs by RN-C who had the HAs practice with each other. HA-L stated HA-L was starting the CNA course in a few weeks but had no formal training regarding vital signs. On 7/17/24 at 12:50 PM, Surveyor interviewed DON-B regarding the delegation of vital signs to HA and CNA staff. DON-B verified HA staff typically did not obtain vital signs but added there were two staff who had been signed off to complete vital signs. DON-B stated CNA staff should obtain routine shower vital signs and could occasionally assist nursing staff with post-fall vital signs while nursing staff did neurological assessments. DON-B stated nursing staff should complete all vital signs and assessments related to medication administration and changes of condition. Surveyor reviewed the HA sign-off sheets for vital signs provided by Nursing Home Administrator (NHA)-A. Surveyor noted HA-L was signed off on 7/4/24 by RN-C. The evaluation indicated HA-L needed more training regarding manual blood pressures. No re-evaluation or follow up was completed. Surveyor noted HA-E was signed off on 6/10/24 by RN-C. The evaluation indicated HA-E needed more training regarding manual blood pressures. No re-evaluation or follow up was completed. An additional evaluation was signed off by RN-C that indicated another HA required additional education and training in all areas. On 7/17/24 at 12:50 PM, Surveyor interviewed NHA-A and DON-B regarding RN-C's ability to evaluate vital signs competency for HAs. DON-B verified RN-C had been verbally reprimanded regarding not documenting proper assessments and had also been written up on 6/24/24 regarding the same concern. DON-B verified DON-B did not follow-up on the evaluations that were done by RN-C.