| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793<br><br>Based on staff interview and record review, the facility did not ensure a Neurologist was notified when medication was not administered for 1 resident (R) (R7) of 4 sampled residents.<br><br>R7 had an order for clozapine (an antipsychotic medication used to treat psychosis) twice daily. R7 did not receive clozapine from 11/23/24 through 11/26/24. R7's Neurologist was not informed that clozapine was not administered. R7 was hospitalized on [DATE] for psychosis symptoms, including attempting to ingest lotion.<br><br>Findings include:<br><br>The facility's undated Notification of Change policy indicates the facility will consult a resident's physician within 24 to 48 hours based upon nursing assessment when there is a significant alteration to a resident's treatment.<br><br>From 1/13/25 to 1/14/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, anxiety, hallucinations, and malnutrition. R7's most recent Minimum Data Set (MDS) assessment, dated 12/22/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R7 had moderately impaired cognition. R7 had an activated Power of Attorney for Healthcare (POAHC).<br><br>Surveyor reviewed R7's physician orders and Medication Administration Record (MAR). R7 had an order for clozapine 25 milligrams (mg) twice daily for psychosis related to Parkinson's disease. According to R7's November 2024 MAR, R7 did not receive clozapine from 11/23/24 through 11/26/24 for a total of 8 missed doses. R7 was hospitalized on [DATE] for increased behavioral symptoms, including attempting to ingest lotion.<br><br>On 1/14/25 at 12:41 PM, Surveyor interviewed Neurology Registered Nurse (RN)-N regarding R7's missed clozapine. RN-N stated the Neurologist was not aware that R7 did not receive clozapine as ordered. RN-N verified the facility should have notified the Neurology clinic if there were concerns with R7's medication, especially clozapine which is highly monitored and can lead to an increased risk of psychosis symptoms when stopped. |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793<br><br>Based on observation, staff interview, and record review, the facility did not provide care and treatment to ensure the highest practicable well being for 3 residents (R) (R7, R3, and R5) of 13 sampled residents.<br><br>R7 was admitted to the facility with a deep brain stimulator (DBS) for Parkinson's disease. Staff did not appropriately apply or charge the DBS as ordered.<br><br>R3's care plan indicated R3 had an intimate relationship with R2. When R3 had a change of condition, including a decreased level of cognition, staff did not complete an updated assessment.<br><br>R5 had a diagnosis of fungal candidiasis (a type of yeast infection). Oral care was not provided per R5's care plan.<br><br>Findings include:<br><br>The facility's Comprehensive Care Plan policy, revised 5/1/21, indicates it is the policy of the facility to promote seamless interdisciplinary care for residents based on assessment, planning, treatment, service, and intervention. It is used to plan for and manage resident care as evidenced by documentation from admission through discharge .The care plan will identify priority problems, be addressed by the Interdisciplinary Team, and reflect the resident's strengths, limitations, and goals. The care plan will be complete, current, realistic, time-specific, and appropriate to each resident's individual needs .Our purpose is to ensure each resident is provided with individualized, goal-directed care which is reasonable, measurable, and based on their needs. A resident's care plan should have the appropriate interventions and provide a means of interdisciplinary communication to ensure continuity of care.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's The Right to Consent to Intimate Relationships policy, revised 9/29/22, indicates staff will use a consistent process for determining residents' capacity to consent to intimate sexual relationships .support residents in their need for intimacy and/or sexual intimacy .provide a consistent approach and process for staff to follow when residents express desire for intimacy and/or sexual intimacy .prevent sexual assault and/or abuse and exploitation of vulnerable residents .Recognizing behaviors and identifying appropriate interventions involves the following steps: 1. Determine Capacity: To determine the capacity and ability to consent, staff will use the Assessment for Consent for Physical/Sexual and Intimate Expressions. 2. Develop an intimacy care plan. 3. Assess sexual knowledge and provide education as needed. When appropriate, staff may do the following: a. Collect data by questioning staff who are familiar with the residents .c. Discuss the relationship with the residents themselves. d. Review the record and evaluations related to the residents' capacity to make decisions. e. Check the resident's record to see if the physician has deemed the resident to be capable of choice . f. If one or both residents have a cognitive impairment or dementia, it should be considered whether the residents' remaining abilities are sufficient to allow them to choose to be sexually intimate with another person .Consent may be obtained through overt actions when a resident lacks the ability to express themselves verbally. A person can withdraw consent at any time .A person's lack of verbal or physical resistance does not constitute consent .Once capacity is determined: a. Continue conversations with residents to determine the parameters of consent including the type(s) of sexual intimacy. b. Document all conversations in the residents' record .d. Check for appropriate decision-making documents such as Guardianship and/or Healthcare Power of Attorney .Family members may not interfere in sexual relationships between two consenting alert, oriented, and cognitively intact adults .Interventions are reviewed in care conferences with the appropriate residents and/or family members quarterly and with any condition changes.<br><br>The facility's Change of Condition Process, dated 3/1/21, indicates a significant change of condition is a major decline or improvement in a resident's status that: i. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. ii. Impacts more than one area of the resident's health status. iii. Requires interdisciplinary review and/or revision of the care plan.<br><br>1. On 1/13/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, anxiety, hallucinations, and malnutrition. R7's most recent Minimum Data Set (MDS) assessment, dated 12/22/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R7 had moderately impaired cognition. R7 had an activated Power of Attorney for Healthcare (POAHC).<br><br>R7's hospital admission paperwork, dated 4/19/24, indicated R7 had a DBS (a surgically implanted device that treats movement disorders and other neurological conditions by delivering electrical pulses to the brain) implanted in 2023.<br><br>An admission progress note, dated 4/12/24, indicated R7 was admitted with a DBS.<br><br>R7's comprehensive care plan, dated 5/9/24, indicated R7 had Parkinson's disease and a DBS. The care plan did not contain interventions for monitoring or charging the device. On 9/11/24, an intervention was added to charge the DBS once a day every other day with neck sling during lunch and remove per schedule. On 9/17/24, an intervention was added to keep the DBS charger in the Certified Nursing Assistant (CNA) charting room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R7's Treatment Administration Record (TAR) contained an order to charge the DBS once a day every other day with neck sling during lunch and indicated the charger should not be kept in R7's room. The order indicated the DBS should be on at 11:30 and off at 12:30. Surveyor noted the TAR was initialed by Licensed Practical Nurse (LPN)-G on 1/4/25 and 1/6/25 and by agency Registered Nurse (RN)-M on 1/14/25.<br><br>On 1/13/25, Surveyor observed R7 between 11:30 AM and 12:30 PM and noted R7 was not wearing the charging neck sling.<br><br>On 1/14/25, Surveyor observed R7 between 11:30 AM and 12:30 PM and noted R7 was not wearing the charging neck sling.<br><br>On 1/14/25 at 12:15 PM, Surveyor interviewed Neurology RN-N who verified staff should put the neck sling on R7 for at least a half hour each day to ensure the DBS was charged appropriately. RN-N stated R7 was hospitalized on [DATE] and the Neurologist noted R7's DBS had been turned off since mid-October. RN-N stated if the device is not charged or functioning correctly, R7's Parkinson's symptoms (hallucinations, mobility issues, tremors, drooling, etc.) could worsen.<br><br>On 1/14/25 at 12:34 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified NHA-A was not aware of R7's DBS upon admission. NHA-A stated a company representative came to the facility and educated staff on using and charging the DBS. NHA-A stated the former Director of Nursing (DON) was responsible for the education. NHA-A could not provide evidence that the education was completed. NHA-A was not aware the DBS had a remote control until after R7 was hospitalized on [DATE] and it was discovered that R7 had likely turned off the device with the remote control which was kept in R7's room. When Surveyor asked NHA-A and DON-B the function of the DBS remote, NHA-A and DON-B indicated they were not sure.<br><br>On 1/14/25 at 1:20 PM, Surveyor interviewed RN-M regarding R7's DBS. RN-M verified RN-M initialed R7's TAR on 1/14/24 and checked to make sure R7's neck sling was on the charger in the CNA charting room at 11:30 AM. RN-M verified RN-M worked regularly at the facility but had never placed the charging neck sling on R7. RN-M denied receiving education about R7's DBS.<br><br>On 1/14/25 at 1:31 PM, Surveyor interviewed LPN-G who stated LPN-G had never placed the neck sling on R7 and had only ensured the neck sling was on the charger in the CNA charting room. LPN-G recalled a brief discussion about the DBS several months ago but could not recall details about the training.<br><br>On 1/14/25 at 1:48 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-O who indicated CNA staff do not do anything with R7's DBS. CNA-O stated CNA-O does not usually see the neck sling on R7 during lunch time and is not sure who is responsible but is concerned that R7's Parkinson's symptoms could worsen.<br><br>42423<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. From 1/13/25 to 1/14/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia, lung cancer, breast cancer, and cerebrovascular accident. A Significant Change of Condition (SCOC) MDS assessment, dated 1/8/25, had a BIMS score of 7 out of 15 which indicated R3 had severely impaired cognition. An MDS assessment, dated 11/18/24, had a BIMS score of 9 out of 15 which indicated R3 had moderately impaired cognition. R3 had a Guardian for healthcare decisions.<br><br>A Discharge Summary from R3's hospital stay from 10/4/24 to 10/15/24 indicated R3 had advanced dementia.<br><br>An intimacy care plan indicated R3 chose to exercise R3's right to engage in intimate activity with another resident, including kissing. The care plan contained a goal that R3 would respect R3's self and intimate/sexual partner and exercise safe and appropriate sexual practices. The care plan contained interventions to determine consent capacity quarterly and with any condition changes and reassess consent if cognition declines or body language/response changes with interactions. (All care plan information was dated 11/18/24.)<br><br>An Assessment for Consent for Physical/Sexual/Intimate Expressions, dated 11/18/24 and completed by Nursing Home Administrator (NHA)-A, indicated R3 was moderately cognitively impaired. The assessment indicated R3 had the ability to protect R3's self from exploitation and desired to be in an intimate relationship. For consent, a box was checked that indicated: Re-assess consent if cognition declines or body language/response changes with interaction. A bullet point under Section H indicated to reasses R3 if changes occurred.<br><br>Nurse Practitioner (NP) notes, dated 12/23/24 and 12/30/24, indicated R3 was forgetful per baseline.<br><br>On 1/13/25 at 9:17 AM, Surveyor interviewed R3 regarding R3's relationship status. R3 indicated professors come to R3's room. R3 indicated one kissed R3's hand which R3 liked. R3 indicated there was no other contact with the professor. Surveyor then observed a male resident from across the hall exit his room and walk toward the center of the facility. R3 indicated that was the professor. R3 indicated R3 had no interest or relationship with other residents. R3 was not afraid of anyone at the facility and did not have issues with anyone.<br><br>On 1/13/25 at 10:20 AM, Surveyor observed R3 near the nurses' station in a central area of the facility. R3 was in a Broda chair with the foot rests up and appeared to be asleep. R3's feet were on the foot rests and the chair was tipped slightly back.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/13/25 at 11:20 AM, Surveyor interviewed Social Services (SS)-U who indicated R3 and R2 had a relationship that included holding hands, hugging, and kissing. SS-U indicated staff did not need to tell managers about interactions between R3 and R2. SS-U indicated if more types of interactions occurred, staff would probably tell NHA-A or DON-B. SS-U indicated if R3 is not interested in intimate interactions with R2, R3 tells R2 to get away. SS-U indicated R3 and R2 were assessed for an intimate relationship and usually visited in common areas. SS-U confirmed an assessment was completed for R3 on 11/18/24 and a SCOC MDS assessment was completed on 1/8/25. SS-U indicated an updated intimacy assessment was not completed since R3's SCOC MDS assessment. SS-U talked to R3 weekly and if something more than hand holding, hugging, and kissing was occurring between R3 and R2, staff would make sure R3 could still tell R2 no. SS-U indicated R3 was feisty and vocal and sometimes pushed R2 away and acted like R3 did not know R2. SS-U verified the weekly conversations were not documented in R3 or R2's medical records. When asked when an assessment should be completed to determine if R3 and R2 still consented to a relationship, SS-U indicated SS-U would document if there was a change which there had not been. SS-U spoke with R3 that morning (which was also not documented by SS-U) and indicated R3 was aware the relationship was still going on. When asked if the SCOC MDS assessment prompted SS-U to complete a new assessment, SS-U reviewed R3's MDS assessment and indicated R3 had a change and was now on Hospice. SS-U reviewed R3's BIMS score and indicated R3 went down only 2 BIMS scores but does have cancer so, otherwise, R3 is still pretty with it. SS-U was unsure of the facility's policy about completing an intimacy assessment with a SCOC and indicated staff would complete a quarterly assessment which was due in approximately one month unless R3 could not talk and/or became lethargic. SS-U confirmed some staff were upset by R3 and R2's relationship. SS-U indicated if R3 or R2 complained, SS-U thought it was when R3 had COVID-19 and was tired. SS-U indicated R2 went by R3 and staff told R2 to leave R3 alone.<br><br>R2's Assessment for Consent for Physical/Sexual/Intimate Expressions, completed 11/20/24 by SS-U, indicated R2's BIMs score was 15 out of 15 which indicated R2 was not cognitively impaired. The assessment indicated R2 had the ability to protect R2's self from exploitation and desired to be in an intimate relationship.<br><br>On 1/13/25 at 12:20 PM, Surveyor observed R3 near the nurses' station eating lunch. Surveyor observed R3 pick up beans and carrots with R3's hands and try to put them through a small opening in the lid of R3's cup. Surveyor interviewed R3 again and asked if R3 had a special male friend. R3 responded yes and indicated the friend had dark hair, looked like a girl, and was pretty like a girl. R3 did not know the male's name. (R2 has a beard, mustache, and gray hair).<br><br>On 1/13/25 at 1:15 PM, Surveyor interviewed R2 who indicated R2 had a relationship with R3 but was told by staff that R2 and R3 cannot see each other. R2 stated staff barred me from that hall approximately one month ago and told R2 and R3 they cannot go in each other's rooms. R2 talked to SS-U and indicated R2 and R3 were kissing in public and showing affection for each other prior to that. R2 indicated staff told R2 that R3 did not want to be bothered by R2, however, R3 told R2 that R3 did not say that. R2 indicated staff did whatever they could to block R2 and R3 from interacting and R2 did not push the issue. R2 indicated R3 never said no or pushed R2 away and stated, It was first base. Nothing more.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/13/25 at 2:05 PM, Surveyor interviewed CNA-D who indicated when R3 and R2 are together, staff try to separate them without making them mad. CNA-D indicated R3 and R2 were together recently and CNA-D did not know what to do. CNA-D indicated R2 was on the A wing, however, CNA-D thought R2 was not allowed on that wing. CNA-D indicated R2 could sit with R3 at the nurses' station. CNA-D was not sure what was allowed between R3 and R2 and stated, I just know they try to keep them at the nurses' station. CNA-D indicated R2 is adamant about everything related to R3. CNA-D indicated R2 screams at the CNAs to get food if R3 is hungry and stated, (R2) speaks for (R3). CNA-D did not recall receiving resident intimacy training.<br><br>On 1/13/25 at 2:10 PM, Surveyor interviewed LPN-L who indicated R3 has told R2 no and has stated, I don't want (R2) to touch me. LPN-L indicated LPN-L asks R2 to back up a bit when R2 is near R3. LPN-L stated LPN-L keeps R3 near the nurses' station and will not let R2 down R3's hall because R3's roommate does not like when R2 is in the room. LPN-L indicated LPN-L only saw R3 and R2 sit together and hold hands. LPN-L indicated R3 has dementia, does not know what end is up most days, and has increased confusion.<br><br>On 1/13/25, Surveyor again interviewed SS-U who again confirmed it is SS-U's understanding that R3 and R2 can have an intimate relationship. SS-U indicated, Yes, unless (R3) says no. With regard to staff stopping the relationship, SS-U indicated, If (R3) were comatose and (R2) were kissing (R3), then yes. SS-U reiterated that quarterly assessments were completed. SS-U indicated if R3 declined to the point where R3 could only answer with 3 words, SS-U would complete an assessment as soon as possible. SS-U indicated R3 has good days and bad days and SS-U has not heard R3 say R3 does not want to be by R2.<br><br>On 1/13/25 at 3:44 PM, Surveyor interviewed NHA-A who indicated intimacy education was provided to staff during huddles, however, the education was not documented. NHA-A indicated staff talk about who is allowed with whom and if staff should or should not break them up. NHA-A indicated R3 and R2 were offered private space to visit but R3 did not want private space. NHA-A indicated it did not seem that R3 was looking for more intimacy than light affection. NHA-A indicated R3 will vocalize if someone does what R3 does not want.<br><br>On 1/13/25 at approximately 4:10 PM, Surveyor sat next to R3 near the nurses' station. R2 approached the area, faced R3, and began to speak. R3 did not acknowledge R2 and R2 moved along.<br><br>On 1/14/25 at 10:11 AM, SS-U informed Surveyor that the facility was doing staff education after Surveyor and SS-U's conversation on 1/13/25. SS-U indicated SS-U had been telling staff the only way they would not allow R3 and R2 to be together is if R3 were unconscious and could not speak. SS-U indicated SS-U spoke with R3 that day and asked how things were with R2. R3 stated things were fine. When SS-U asked if R3 was still OK with the relationship, R3 said, Ya. When asked what R3 would do if R3 was not okay with the relationship, R3 stated, I would tell (R2) no.<br><br>On 1/14/25 at 2:04 PM, Surveyor interviewed LPN-G who indicated R2 was touching the back of R3's neck and rearranging R3's hair near the nurses' station on or around 1/5/25 and R3 was not upset. LPN-G indicated staff told R2 that R2 could not do that and asked R2 to leave the area. LPN-G recalled the incident because it was around the time R3 stated that R3 did not want contact from R2 so staff did not allow it. LPN-G indicated R2 and R3 were not supposed to to be in close proximity to each other but stated it was confusing because now staff cannot keep R2 and R3 apart unless R3 does not want contact. LPN-G stated, We try to intervene.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/14/25 at approximately 3:30 PM, Surveyor interviewed R3 with NHA-A present. R3 indicated R3 felt safe but R3's parents had just passed away. When asked about a relationship with R2, R3 indicated R2 was not in a relationship and there was not much hope for marriage. R3 was not able to answer questions about R2, a relationship, or the current time and place. NHA-A then interviewed R3 without Surveyor present and confirmed NHA-A got similar responses as when Surveyor and NHA-A interviewed R3 together.<br><br>Following the interview, Surveyor again reviewed R3's medical record which had an updated assessment, dated 1/14/25, that indicated R3 did not have the capacity to consent to an intimate relationship. R3's care plan was also updated to reflect the change.<br><br>47248<br><br>3. On 1/13/25, Surveyor reviewed R5's medical record. R5 had diagnoses including traumatic brain injury (TBI), chronic respiratory failure, type 2 diabetes mellitus, epilepsy, coma, tracheostomy status, G-tube placement, and reoccurring fungal candidiasis (thrush). R5's MDS assessment, dated 11/22/24, had a BIMS score of 0 out of 15 which indicated R5 was severely cognitively impaired. R5 had an activated healthcare decision maker.<br><br>R5's care plan indicated R5 had an activities of daily living (ADL) self-care performance deficit due to trauma, coma, trach, and G-tube. The care plan indicated R5 required assistance for personal hygiene/oral care and contained an intervention to use a toothette with toothpaste and rinse with mouthwash using toothette (initiated 6/4/21 and revised 4/10/24).<br><br>On 1/13/25 at 11:50 AM, Surveyor interviewed Nurse Practitioner (NP)-H who indicated R5 had reoccurring thrush since April 2024 and had been treated for approximately two weeks each month. NP-H stated R5 had scheduled and as needed Nystatin Mouth/Throat Suspension 100000 units for thrush and scheduled Fluconazole Oral Suspension Reconstituted 40 milligrams/milliliter (mg/ml) for thrush which was initiated in November 2024. NP-H contacted Infectious Disease for other suggestions on how to treat and prevent thrush and was waiting to hear back. NP-H indicated NP-H ordered oral cares which were added to R5's care plan. NP-H stated it is questionable if R5's oral cares are completed as ordered.<br><br>On 1/14/25 at 8:46 AM, Surveyor observed Certified Nursing Assistant (CNA)-D complete oral cares for R5. Surveyor observed CNA-D fill a basin with water and swab R5's mouth with a toothette and water. Surveyor interviewed CNA-D who verified CNA-D did not use toothpaste or mouthwash and preferred to use water to clean R5's mouth.<br><br>On 1/14/25 at 8:54 AM, Surveyor interviewed LPN-G who indicated LPN-G did not complete oral care for R5 that day. LPN-G indicated LPN-G did R5's oral cares frequently and used a toothette and water to clean R5's mouth. LPN-G confirmed LPN-G does not use toothpaste or mouthwash during R5's oral cares.<br><br>On 1/14/24 at 10:45 AM, Surveyor interviewed DON-B who indicated DON-B expects nursing staff to provide care according to a resident's care plan. DON-B indicated R5 bites down on toothettes at times which makes oral care harder to complete. DON-B indicated NP-H increased the amount of times oral care should be completed as a result. DON-B was not aware nursing staff were not following R5's care plan and completed oral care with only water. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248<br><br>Based on observation, staff interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R6) of 13 sampled residents.<br><br>On 1/3/25, R6 fell when staff transferred R6 incorrectly and did not follow R6's care plan. In addition, the facility did not provide staff education in a timely manner.<br><br>Batteries used for motorized wheelchairs were charged in a vacant resident room which did not have appropriate ventilation. The room was used for storage and did not have a door closure in place.<br><br>Findings include:<br><br>The facility's Fall Policy, dated 7/17/24, indicates all residents will receive adequate supervision, assistance, and assistive devices to prevent falls. Each resident will be evaluated for safety risks, including falls and accidents. Care plans will be created and implemented based on individual risk factors to aid in preventing falls. All falls are to be investigated and monitored .<br><br>1. On 1/13/25, Surveyor reviewed R6's medical record. R6 had diagnoses including cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery, polyneuropathy, activity intolerance, fatigue, and hemiplegia. R6's Minimum Data Set (MDS) assessment, dated 1/8/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R6 was not cognitively impaired. R6 was R6's own decision maker and discharged from the facility on 1/6/25.<br><br>R6's care plan indicated R6 had an activities of daily living (ADL) self-care performance deficit due to activity intolerance, fatigue, hemiplegia, and stroke. The care plan contained an intervention to transfer R6 with a full body (Hoyer) lift and the assist of two staff (initiated 12/29/24 and revised 12/30/24).<br><br>An admission progress note, dated 12/26/24, indicated R6 was admitted to the facility due to a stroke and did not have use of the left side. Per the hospital, R6 was a sit-to-stand transfer. Upon admission, staff transferred R6 with a sit-to-stand lift and noted it was not safe. Therapy assessed R6 and changed R6's transfer status to a two person assist with a full body (Hoyer) lift. R6's care plan was updated.<br><br>On 1/13/25, Surveyor requested the investigation for R6's fall on 1/3/25. The fall investigation indicated the fall occurred because a Certified Nursing Assistant (CNA) did not follow R6's care plan and transferred R6 with a sit-to-stand lift. During the transfer, R6 indicated R6 felt weak and fell . A Staff Development Program Attendance Record, dated 1/3/25, was included in the investigation. Surveyor noted transfer education was provided to nursing staff. The attendance sheet for the education included 7 CNAs, 10 Licensed Practical Nurses (LPNs), and 1 Registered Nurse (RN).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/13/25, Surveyor reviewed the facility's staff list and noted 21 CNAs were employed by the facility. Surveyor noted the Staff Development Program Attendance Record did not contain the names or signatures of 15 CNAs.<br><br>On 1/13/25 at 2:15 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated Director of Nursing (DON)-B was continuing to work on staff education related to safe transfers and following residents' care plans. NHA-A confirmed the 15 CNAs not listed on the attendance sheet had not received education.<br><br>On 1/14/25 at 9:40 AM, DON-B approached Surveyor with an updated Staff Development Program Attendance Record (Topic: Transfers), dated 1/3/25. Surveyor reviewed the attendance record and noted 14 additional CNAs were trained and 5 nursing staff or administration members were added to the attendance record.<br><br>On 1/14/25 at 11:45 AM, Surveyor interviewed NHA-A who indicated DON-B did additional education with staff in-person or over the phone on the evening of 1/13/25.<br><br>42423<br><br>2. On 1/13/25 at 12:45 PM, Surveyor observed a vacant resident room (room [ROOM NUMBER]) on the D wing which contained 3 electric wheelchair battery chargers, one free-standing battery, and two electric wheelchairs with batteries that were connected to chargers and being charged in the room. The room had a bed with a mattress, two wooden nightstands (where the chargers/battery were set), a roll of toilet paper next to the chargers, two room-dividing curtains, a wooden dresser, a hand sanitizing dispenser, and 18 empty cardboard boxes. The door was open to the hallway and did not have a closer attached. The door contained a paper sign that read: Make sure both chairs are plugged in and turn them off otherwise, they won't charge.<br><br>The room contained a suspended tile ceiling with a hole in one of the ceiling tiles that was approximately 4 inches wide in a circular pattern and open to the structure above the ceiling. A sprinkler head was observed. There was a shared bathroom with a vacant room on the other side. The bathroom doors were closed to both rooms. The rooms on D wing were vacant. The beginning of the D wing hallway was used as an access way to an outside courtyard where residents smoked and spent time outside.<br><br>Surveyor noted one of the chargers was labeled as a sealed lead-acid charger and contained a message that read, Warning: Explosive gases. Prevent flames and sparks. Provide adequate ventilation during charging . A second charger read, Warning! .The battery can emit explosive gases while charging. Do not expose to flames and sparks. Provide adequate ventilation during charging . A third charger read, Warning: To reduce the risk of fire, do not use charger near flammable materials or vapors .Battery gases are explosive. Use in well ventilated areas. Each of the 3 chargers contained a resident's name.<br><br>On 1/13/25 at 1:00 PM, Surveyor interviewed Life Safety Consultant (LSC)-S who indicated ventilation should be provided in the area where the batteries were charging. LSC-S also indicated because the room was used for storage including boxes, a closer was needed on the door to the hallway. LSC-S indicated the hole in the ceiling allowed heat to escape above the ceiling which could prolong the activation of the sprinkler head.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/13/25 at 1:09 PM, Surveyor observed R2 near room [ROOM NUMBER]. R2 confirmed R2's wheelchair was charged in room [ROOM NUMBER].<br><br>On 1/13/25 at 4:00 PM, Surveyor interviewed Maintenance Staff (MS)-T who indicated the Maintenance Director was on vacation. MS-T indicated MS-T believed the hole in the ceiling was due to removal of the room vent cap that was being used in a different room. When Surveyor held up a single-ply piece of toilet paper to the spot that MS-T indicated was a vent in the ceiling, MS-T confirmed the toilet paper did not move. (On a prior call with LSC-S, LSC-S confirmed there would be air flow if ventilation was in place.) MS-T (who is taller than Surveyor) also held the toilet paper to the area and stated, I don't think there is any air coming or going from there. No other area was noted to be ventilated in the room. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794<br><br>Based on observation, staff and resident interview, and record review, the facility did not ensure they had sufficient nursing staff to provide care and services to meet the needs of 6 residents (R) (R1, R13, R11, R10, R2, and R12) of 13 sampled residents.<br><br>R1, R13, R11, R10, and R2 reported cares were not completed timely due to staffing shortages.<br><br>Multiple staff stated resident cares (including for R12) were not provided timely due to staffing shortages.<br><br>Findings include:<br><br>The Facility Assessment, dated 8/8/24, states under subsection Staff Type that the facility provides care and services based upon the needs of the resident population .Staffing Plan indicates the designated position and total number needed on average or range: Licensed nursing providing direct care is 5-9. Nurse aides are listed as 8-15 with other nursing personnel listed as 2-3 (Director of Nursing (DON), Unit manager, Minimum Data Set (MDS) Coordinator). Individual Staff Assignment: Staffing patterns are reviewed to evaluate the needs for the day, following day, and the week. Staffing assignments are modified based on residents' needs in collaboration with nursing staff, the DON, and the Scheduler. Staffing assignments are as consistent as possible to promote continuity of care. Staff members may be assigned to float between work areas during times of high care needs.<br><br>1. From 1/13/25 through 1/14/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including chronic pulmonary edema, morbid obesity, type 2 diabetes, pneumonia, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD). R1's MDS assessment, dated 12/16/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was not cognitively impaired. R1 was R1's own decision maker.<br><br>A care plan, dated 11/11/24, indicated R1 required the assistance of one staff for bathing and activities of daily living (ADLs) and the assistance of two staff for transfers with a full body lift.<br><br>On 1/13/24 at 11:08 AM, Surveyor interviewed R1 who expressed staffing concerns, especially on the night (NOC) shift. R1 stated on average it takes an hour or more for staff to answer R1's call light and there were times when R1 was incontinent because R1 could not wait any longer for staff. R1 stated only Certified Nursing Assistants (CNAs) answer call lights, not nurses or management staff. R1 stated NOC shift agency staff often do not show up which leaves only 1 CNA on the wing. R1 stated staff provide the bare minimum for cares or rush through cares because there is not enough staff.<br><br>2. From 1/13/25 to 1/14/25, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including heart failure, diabetes mellitus, and malnutrition. R13's MDS assessment, dated 12/13/24, had a BIMS score of 15 out of 15 which indicated R13 was not cognitively impaired. The MDS also indicated R13 required moderate staff assistance for personal hygiene and maximal staff assistance for toileting, showering, and lower body dressing.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/13/25 at 9:15 AM, Surveyor entered the A wing and noted 4 residents' call lights were activated. At 9:21 AM, the call lights were still activated. Surveyor did not observe a CNA in the hallway but observed Licensed Practical Nurse (LPN)-L passing medication. At 9:22 AM, Surveyor noted an additional call light was activated. LPN-L briefly entered the room, turned the call light off, said LPN-L would be tied up for a little while, exited the room, and shut the door. At 9:23 AM, Surveyor noted the other 4 residents' call lights were still activated and staff had not provided care yet. There were no CNAs in the hallway at that time.<br><br>On 1/13/25 at 9:24 AM, Surveyor noted R13's call light had been activated since Surveyor entered the A wing. Surveyor interviewed R13 who confirmed R13 activated the call light because R13 had not received breakfast. R13 indicated R13 activated the call light approximately 30 minutes prior. R13 stated, I am looking to get out of here. There is such a transient staff because they cannot hold staff here. I have seen probably 4 nurses quit. I have seen about 6 of the aides just not show up or walk off the job. It is just horrible. R13 indicated the facility hired only agency staff who did not know what they were coming into. R13 saw staff work once or twice and not return. R13 indicated the main issue was lack of help and stated, When a girl comes in at 6:00 AM and there are at least 20-24 patients on this wing and she has 14 lights on, what is she supposed to do? Then, if the other aide does not show up, what is she supposed to do? Even if one more aide comes, it's not enough help. I know what's going on. I do not have dementia.<br><br>On 1/13/25 at 9:35 AM, CNA-P responded to R13's call light. When R13 stated R13 wanted breakfast, CNA-P turned off the call light and exited the room. CNA-P returned at 9:39 AM and told the nurse that R13 did not receive breakfast. The nurse indicated staff wait to deliver R13's breakfast until R13 requests it due to R13's past complaints about cold food. A short time later, staff delivered R13's breakfast tray. R13 requested Surveyor stay to finish the conversation while R13 ate. R13 indicated R13's therapy sessions have been delayed because R13 has had to wait for staff to answer R13's call light and provide morning cares. R13 indicated once R13 activated the call light for incontinence care prior to therapy and nobody came. When the therapist entered R13's room between 9:00 AM and 9:30 AM, R13 indicated R13 wanted to be cleaned up prior to therapy and staff had not been in R13's room yet that morning. R13 kept the call light on but stated staff did not come. When the therapist came back and R13 was still not ready, the therapist agreed to do therapy with a second resident and come back. R13 stated R13 was still soaked after an hour and was not ready when the therapist came back a third time. R13 indicated staff did not answer R13's call light until 10:30 AM or 11:00 AM and the therapist wrote a report to the facility. R13 stated, The girl said she came in and cleaned me up. She lied and then finally she admitted she lied. R13 indicated R13 was not interviewed about the incident.<br><br>3. From 1/13/25 to 1/14/25, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including cerebrovascular accident, urinary tract infection (UTI), and diabetes mellitus. R11's MDS assessment, dated 1/9/25, had a BIMS score of 15 out of 15 which indicated R11 was not cognitively impaired. The MDS also indicated R11 required staff assistance for ADLs and maximal assistance for toilet transfers.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/13/25 at 9:47 AM, Surveyor returned to the A wing and noted R11's call light (which was noted to be on at 9:15 AM) was still activated. Surveyor interviewed R11 who confirmed the call light had been on for a while and stated staff had not assisted R11 yet. R11 expressed frustration and indicated it was normal to have to wait for staff to answer the call light. Shortly after Surveyor entered R11's room, CNA-P entered the room. When R11 indicated R11 needed use the bathroom, CNA-P stated CNA-P would find help, turned off the call light, and exited the room.<br><br>On 1/13/25 at 9:48 AM, Surveyor interviewed CNA-P who indicated CNA-P needed another staff to assist R11. CNA-P indicated CNA-P had a helper that day but was alone on a unit approximately 30% of the time which was really hard. CNA-P indicated CNA-P tries to be a thorough and compassionate caregiver but it is hard when there is not enough help. CNA-P indicated when CNA-P is alone, the facility tries to call agency staff but it is still hard if agency staff come in.<br><br>4. From 1/13/25 to 1/14/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including fracture of unspecified part of neck of left femur, type 2 diabetes, Crohn's disease of small intestine without complications, gout, and myoneural disorder. R10's MDS assessment, dated 12/29/24, had a BIMS score of 15 out of 15 which indicated R10 was not cognitively impaired. The MDS also indicated R10 required staff supervision for mobility and toileting and had lower extremity impairment on one side.<br><br>On 1/14/25 at 11:21 AM, Surveyor interviewed R10 who indicated it was a common occurrence to wait long periods for staff to answer the call light. R10 indicated it was worse when R10 was first admitted because R10 could not get to the bathroom without staff and once waited an hour on the PM shift. R10 stated R10 also waited 35 minutes and had to figure out a way to transfer R10's self from the bed to the wheelchair so R10 was not incontinent. R10 worked with therapy since then and is now allowed to transfer independently. R10 indicated when R10 asks for something staff seem to forget. R10 activated the call light for as needed (PRN) medication, however, staff shut the call light off and R10 did not receive the medication. R10 stated a CNA twice told the nurse that R10 requested medication but the nurse stated they were never told. R10 stated it took approximately three and half hours for R10 to receive the pain medication which was only provided because R10 asked again when the nurse administered R10's scheduled medication. R10 indicated R10's left leg and hip were in pain and R10's PRN pain medication was now scheduled. R10 received a dose of pain medication at supper last night (1/13/25) and was supposed to receive another dose at approximately midnight but did not receive a dose until 5:00 AM or 6:00 AM that morning. R10 stated nursing staff are understaffed and overworked but residents should not go without medication.<br><br>On 1/14/25 at 11:45 AM, Surveyor reviewed R10's Medication Administration record (MAR) which indicated R10 did not receive a dose of tramadol 50 mg (which was ordered every 6 hours for pain) around midnight. A progress note, dated 1/14/25 and written by LPN-E, indicated the medication was requested at 1:40 AM which was outside the administration time and too close to the next dose.<br><br>On 1/14/25 at 3:03 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-V who confirmed R10's NOC shift dose of tramadol was not administered by LPN-E because the time it would have been administered was too close to the AM administration time.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. From 1/13/25 to 1/14/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including chronic pain syndrome, bilateral below-knee amputation, hearing loss, and emphysema. R2's MDS assessment, dated 11/6/24, had a BIMS score of 15 out of 15 which indicated R2 was not cognitively impaired.<br><br>On 1/13/25 at 9:50 AM, Surveyor interviewed R2 who resides on the B wing. R2 indicated call lights can take 40 minutes to an hour to answer. R2 indicated the wait depends on how many staff are working.<br><br>6. From 1/13/25 to 1/14/25, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including traumatic brain injury, neurogenic bladder, hemiplegia, hemiparesis, and seizure disorder. R12's MDS assessment, dated 11/2/24, had a BIMS score of 7 out of 15 which indicated R12 had severely impaired cognition. The MDS also indicated R12 was dependent on staff for toileting and transfers.<br><br>On 1/13/25 at 2:17 PM, Surveyor interviewed LPN-L who indicated there is not enough staff to complete resident cares. LPN-L indicated residents are frequently wet from urine at the start of the AM shift and also on the PM and NOC shifts. LPN-L indicated last Monday (1/6/25) or Tuesday (1/7/25), an agency CNA on NOC shift tried to leave before the end of the shift. LPN-L indicated the CNA could not leave because a replacement was not there yet. LPN-L indicated the CNA found someone else to sign that the CNA could leave early. The NOC shift nurse told LPN-L that they had trouble finding the CNA during the shift who was at one point observed on the couch on their phone. LPN-L indicated R12 was found urine-soaked by AM staff that morning. R12's bedding was wet all the way up toward the head of the bed. LPN-L confirmed residents have also been left in stool, including R12 last week. LPN-L told management it is too busy on the PM shift for just two nurses. LPN-L indicated CNAs try but there are more resident behaviors, medications to pass, and falls on the PM shift. LPN-L indicated there are also not enough staff on the NOC shift and if a resident falls or codes you are screwed. LPN-L confirmed LPN-L works on the A wing which is heavy care.<br><br>Additional observations and interviews:<br><br>On 1/13/25 at 1:21 PM, Surveyor interviewed CNA-C who worked at the facility since August 2024. CNA-C primarily worked the AM shift, but also worked the NOC shift. CNA-C indicated there is not enough staff to meet residents' needs and stated at times there are only 2 CNAs working. CNA-C stated staff are told by management that is enough, however, it is not enough. CNA-C is often unable to complete tasks and has to pass tasks to the next shift or stay over. CNA-C stated scheduled showers are often not completed and staff use the weekend to catch up. CNA-C stated staff usually discover in the morning that multiple residents' briefs were not changed and the residents are soaked. CNA-C stated agency staff frequently call in or do not show up for their shift and are not replaced. CNA-C brought the call light wait times and staffing concerns to management with no resolution.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/13/24 at 1:51 PM, Surveyor interviewed CNA-D who worked at the facility for 2 years. CNA-D does not feel there are enough staff to meet residents' needs. CNA-D stated the facility has 2 CNAs on each wing at times but not consistently. CNA-D stated agency staff do not show up 85% of the time and CNA-D is left alone on a wing. CNA-D stated agency staff also walk out during the middle of their shift. CNA-D is not able to complete all tasks, including showers, repositioning, and 2 hour rounds. CNA-D reported the concerns to management and was told there is enough staff. CNA-D stated management does not help on the floor. CNA-D stated CNA-D has discovered on the NOC shift that some of the residents have not been checked.<br><br>While in the nurses' station on 1/13/25 at 2:00 PM, Surveyor heard CNA-Q being told that CNA-Q would be training a new staff that evening. CNA-Q replied, I am training someone? It is is only my second day.<br><br>On 1/13/25 at 3:51 PM, Surveyor observed CNA-P getting ready to leave following CNA-P's shift (6:00 AM to 2:00 PM). CNA-P stated, I am finally leaving. I had a couple days of charting to catch up on.<br><br>On 1/13/25 at 4:15 PM, Surveyor interviewed CNA-Q who verified CNA-Q was training a new employee on CNA-Q's second day as an employee. CNA-Q worked as an agency CNA in the past for facilities. Surveyor observed CNA-Q call someone to work out scheduling dates. CNA-A stated, It is crazy here. I am training someone. Surveyor then heard a resident on the E wing call loudly for help. CNA-Q ended the call and assisted the resident.<br><br>On 1/13/25 at 4:33 PM, Surveyor interviewed CNA-P who indicated it was CNA-P's second day in the facility and CNA-P was being trained by CNA-Q. On CNA-P's first day, CNA-P was alone on the B wing and was told to wing it and that no one was coming to help. CNA-P called 16 to 17 times for help repositioning residents but no one came. When CNA-P reported for work on 1/13/25, staff told CNA-P that management increased staffing because Surveyors were in the facility.<br><br>On 1/14/25 at 5:37 AM, Surveyor interviewed LPN-E who worked at the facility for a month and just submitted a 2-week notice. LPN-E usually worked the NOC shift and stated there were usually 2 CNAs and 1 nurse for the entire facility. LPN-E stated LPN-E did not believe there was enough staff. LPN-E stated rounds get done, but it takes longer due to staffing. LPN-E stated call lights are consistently activated through the night and there are not enough staff to answer them timely. LPN-E indicated there are times when residents who are usually continent are incontinent because they can not wait for their call light to be answered. LPN-E reported concerns to Nursing Home Administrator (NHA)-A, DON-B and Human Resources staff but nothing was done. LPN-E brought solutions to management but they were not acknowledged. LPN-E stated the CNAs try hard, but it is too much for 2 CNAs to handle. LPN-E tries to help the CNAs answer call lights and assist with changing and bathroom needs, however, LPN-E constantly administers as needed (PRN) medications to residents and is unable to assist as much as LPN-E would like.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/14/25 at 6:06 AM, Surveyor interviewed CNA-F who worked at the facility since August 2024. CNA-F stated the NOC shift is usually staffed with 2 CNAs and 1 nurse. CNA-F does not feel that is enough staff. CNA-F stated call lights never stop during the night. CNA-F indicated 2 residents on the E wing attempt to self-transfer and are high fall risks. CNA-F does 2 hour rounds, however, they take longer than 2 hours to complete. CNA-F acknowledged CNA-F was still working on 4:00 AM rounds at time of the interview. CNA-F admitted there are times when residents who are continent have accidents because their call lights are not answered timely. CNA-F indicated Hoyer transfers require 2 staff, however, there have been times when CNA-F had to use the Hoyer lift alone because there were no staff available to help. CNA-F stated there were times when CNA-F was the only CNA on the NOC shift. CNA-F had not expressed concerns to administration for fear of retaliation. CNA-F stated staffing has gotten worse since CNA-F started and indicated a couple nurses help answer call lights but the majority do not.<br><br>On 1/14/25 at 9:49 AM, Surveyor interviewed NOC shift Registered Nurse (RN)-I who indicated it would be helpful if there were 3 CNAs on NOC shift at all times to allow A, B and E wings to have one CNA each so they can assist each other with residents who require two staff. RN-I prefers to have two nurses on NOC shift, but indicated 3 CNAs would be most helpful. RN-I indicated numerous residents require two staff for repositioning and transfers which leaves 2 CNAs in one spot and unable to help other residents.<br><br>On 1/14/25 at 10:43 AM, Surveyor interviewed NHA-A who stated the facility does not have a call light log to verify how long call lights are activated. NHA-A stated when a call light concern is received, NHA-A makes observations and completes interviews. NHA-A denied there were any staff concerns regarding insufficient staffing and stated staff always say they want more staff. NHA-A acknowledged an agency CNA brought up the need for 3 CNAs on the NOC shift but stated when NHA-A followed up with the CNA, the CNA walked away and did not want to talk about it. NHA-A stated the facility has an on-call clinical staff who looks at the schedule and take steps to get spots filled when there are call ins. NHA-A stated there is a nurse on-call at all times to provide assistance if needed. NHA-A confirmed the nurse also works as a CNA if needed. NHA-A denied CNAs had to work alone and indicated if it occurred, it was only for a short time until someone came in. NHA-A stated there is always a nurse in the building to help.<br><br>On 1/14/25 at 1:00 PM, Surveyor reviewed the nurse staffing schedule for the 1/13/25 to 1/14/25 NOC shift and noted there was 1 LPN and 2 CNAs (1 facility staff and 1 agency staff) scheduled. The facility's census was 55. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942<br><br>Based on staff and resident interview and record review, the facility did not ensure accurate administration of medication for 2 residents (R) (R4 and R10) of 13 sampled residents.<br><br>R4 was administered multiple scheduled medications late in December 2024 and January 2025.<br><br>R10's scheduled pain medication was not administered on the 1/13/25 night (NOC) shift. In addition, R10's medications were left with R10 to take without staff supervision. R10 did not have a self-administration of medication assessment that indicated R10 could safely and accurately self-administer medication.<br><br>Findings include:<br><br>The facility's Administration Procedures for All Medications policy, revised January 2018, indicates: To administer medications in a safe and effective manner .C. Review 5 rights (3) times .a) Check Medication Administration Record (MAR)/Treatment Administration Record (TAR) for order .c) If unfamiliar with the medication, consult a drug reference .or pharmacist for more information .P. Notification of Physician/Prescriber: 1) Persistent refusals .<br><br>The facility's Self-Administration of Medications policy, revised January 2018, indicates: 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 resident and other residents of the facility and there is a prescriber's order to self-administer.<br><br>1. From 1/13/25 to 1/14/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including chronic venous hypertension with ulcer of right lower extremity (RLE), diabetes, anxiety, cellulitis of RLE, and depression. R4's Minimum Data Set (MDS) assessment, dated 11/5/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 was not cognitively impaired. R4 made R4's own healthcare decisions.<br><br>On 1/14/25, Surveyor reviewed R4's December 2024 MAR and noted the following scheduled medications were administered late:<br><br>~ Vitamin C (supplement) Oral Tablet 500 milligrams (mg). Give 1 tablet by mouth in the morning. Scheduled for 6:30 AM daily. The mediation was administered on 12/12/24 at 8:17 AM, 12/16/24 at 7:48 AM, and 12/31/24 at 7:57 AM.<br><br>~ Apixaban (blood thinner) Oral Tablet 5 mg. Give 1 tablet by mouth two times a day. Scheduled for 4:00 PM. The medication was administered on 12/6/24 at 5:13 PM, 12/8/24 at 6:25 PM, 12/9/24 at 6:28 PM, 12/13/24 at 5:13 PM, 12/18/24 at 5:26 PM, 12/31/24 at 5:17 PM, 1/1/25 at 5:10 PM, 1/3/25 at 6:54 PM, and 1/6/25 at 5:35 PM.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ~ Duloxetine (anti-depressant) HCl Oral Capsule Delayed Release Sprinkle 60 mg. Give 1 capsule by mouth two times a day. Scheduled for 4:00 PM. The medication was administered on 12/6/24 at 5:14 PM, 12/8/24 at 6:25 PM 12/9/24 at 6:28 PM, 12/13/24 at 5:13 PM, 12/18/24 at 5:26 PM, 12/31/24 at 5:17 PM, 1/1/25 at 5:09 PM, 1/3/25 at 6:53 PM, and 1/6/25 at 5:35 PM.<br><br>~Guaifenesin (for congestion) ER Oral Tablet Extended Release 12 Hour. Give 600 mg two times a day. Scheduled for 4:00 PM. The medication was administered on 12/4/24 at 7:58 PM, 12/6/24 at 5:13 PM, 12/8/24 at 6:25 PM, 12/9/24 at 6:28 PM, 12/13/24 at 5:14 PM, 12/18/24 at 5:27 PM, 12/31/24 at 5:17 PM, 1/1/25 at 5:10 PM, 1/3/25 at 6:54 PM, and 1/6/25 at 5:35 PM.<br><br>~ Lactobacillus Probiotic (prophylaxis) Oral Tablet. Give 2 tablets by mouth two times a day. Scheduled for 4:00 PM. The medication was administered on 12/6/24 at 5:13 PM, 12/8/24 at 6:25 PM, 12/9/24 at 6:29 PM, 12/13/24 at 5:14 PM, 12/18/24 at 5:27 PM, 12/31/24 at 5:17 PM, 1/1/25 at 5:10 PM, 1/3/25 at 6:54 PM, and 1/6/25 at 5:36 PM.<br><br>~ Magnesium Oxide (supplement) Oral Tablet 400 mg. Give 1 tablet by mouth two times a day. Scheduled for 4:00 PM. The medication was administered on 12/6/24 at 5:13 PM, 12/8/24 at 6:26 PM, 12/9/24 at 6:29 PM, 12/13/24 at 5:14 PM, 12/18/24 at 5:30 PM, 12/31/24 at 5:17 PM, 1/1/25 at 5:10 PM, 1/3/25 at 6:55 PM, and 1/6/25 at 5:36 PM.<br><br>~ Metformin (for diabetes) HCl Oral Tablet 500 mg. Give 1 tablet by mouth two times a day. Scheduled for 4:00 PM. The medication was administered on 12/6/24 at 5:13 PM, 12/8/24 at 6:26 PM, 12/9/24 at 6:29 PM, 12/13/24 at 5:15 PM, 12/18/24 at 5:31 PM, 12/31/24 at 5:17 PM, 1/1/25 at 5:10 PM, 1/3/25 at 6:55 PM, and 1/6/25 at 5:37 PM.<br><br>~ Norethindrone Acetate Oral Tablet 5 mg. Give 1 tablet by mouth two times a day. Scheduled for 4:00 PM. The medication was administered on 12/6/24 at 5:13 PM, 12/8/24 at 6:26 PM, 12/9/24 at 6:29 PM, 12/13/24 at 5:15 PM, 12/18/24 at 5:31 PM, 12/31/24 at 5:17 PM, 1/1/25 at 5:11 PM, 1/3/25 at 6:56 PM, and 1/6/25 at 5:38 PM.<br><br>~Sulfamethoxazole-Trimethoprim (antibiotic) Oral Tablet 800-160 mg. Give 1 tablet by mouth two times a day. Scheduled for 4:00 PM. The medication was administered on 1/1/25 at 5:11 PM, 1/3/25 at 6:57 PM, and 1/6/25 at 5:38 PM.<br><br>~ Ropinirole HCl Oral Tablet 0.25 mg. Give 1 tablet by mouth at bedtime for restless leg syndrome. Scheduled for 6:00 PM. The medication was administered on 12/1/24 at 8:04 PM, 12/4/24 at 7:59 PM, 12/5/24 at 8:48 PM, 12/6/24 at 7:48 PM, 12/7/24 at 11:04 PM, 12/9/24 at 8:44 PM, 12/10/24 at 8:19 PM, 12/12/24 at 7:16 PM, 12/13/24 at 8:06 PM, 12/14/24 at 7:48 PM, 12/15/24 at 8:27 PM, 12/16/24 at 8:36 PM, 12/17/24 at 7:41 PM, 12/18/24 at 10:21 PM, 12/19/24 at 7:09 PM, 12/20/24 at 8:33 PM, 12/21/24 at 8:11 PM, 12/23/24 at 7:34 PM, 12/24/24 at 8:02 PM, 12/25/24 at 10:24 PM, 12/26/24 at 8:57 PM, 12/27/24 at 7:37 PM, 12/28/24 at 9:12 PM, 12/29/24 at 8:17 PM, 12/30/24 at 9:10 PM, 1/1/25 at 8:55 PM, 1/2/25 at 8:56 PM, 1/4/25 at 7:13 PM, 1/6/25 at 8:38 PM, 1/7/25 at 8:17 PM, 1/8/25 at 8:26 PM, 1/9/25 at 7:51 PM, 1/10/25 at 8:27 PM, 1/11/25 at 8:49 PM, 1/12/25 at 9:25 PM, and 1/13/25 at 8:18 PM.<br><br>~ Metoprolol Tartrate 50 mg tablet. Give 0.5 tablet by mouth two times a day for high blood pressure. Scheduled for 8:00 PM. The medication was administered on 12/7/24 at 10:31 PM, 12/8/24 at 9:45 PM, 12/25/24 at 10:40 PM, 12/28/24 at 9:01 PM, 12/30/24 at 9:10 PM, 12/31/24 at 10:29 PM, and 1/12/25 at 9:25 PM.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ~ Buspirone HCl Oral Tablet 5 mg. Give 1 tablet by mouth three times a day for anxiety. Scheduled for 8:00 PM. The medication was administered on 12/7/24 at 10:30 PM, 12/8/24 at 9:43 PM, 12/18/24 at 10:20 PM, 12/25/24 at 10:22 PM, 12/28/24 at 9:11 PM, 12/30/24 at 9:09 PM, 12/31/24 at 10:01 PM, and 1/12/25 at 9:25 PM.<br><br>~ Ursodiol Oral Capsule 300 mg. Give 2 capsules by mouth three times a day for gallstones. Scheduled for 8:00 PM. The medication was administered on 12/7/24 at 10:45 PM, 12/8/24 at 9:44 PM, 12/18/24 at 10:21 PM, 12/25/24 at 10:21 PM, 12/28/24 at 9:12 PM, 12/30/24 at 9:10 PM, 12/31/24 at 9:56 PM, and 1/12/25 at 9:25 PM.<br><br>~ Gabapentin Oral Tablet 800 mg. Give 1 tablet by mouth three times a day for neuropathy pain. Scheduled for 8:00 PM. The medication was administered on 12/7/24 at 10:30 PM, 12/8/24 at 9:43 PM, 12/18/24 at 10:20 PM, 12/25/24 at 10:22 PM, 12/28/24 at 9:11 PM, 12/30/24 at 9:10 PM, 12/31/24 at 9:54 PM, and 1/12/25 at 9:25 PM.<br><br>~ Topiramate Oral Tablet 100 mg. Give 1 tablet by mouth two times a day for polyneuropathy. Scheduled for 8:00 PM. The medication was administered on 12/7/24 at 10:31 PM, 12/8/24 at 9:43 PM, 12/18/24 at 10:21 PM, 12/25/24 at 10:23 PM, 12/28/24 at 9:12 PM, 12/30/24 at 9:10 PM, 12/31/24 at 9:56 PM, and 1/12/25 at 9:25 PM.<br><br>~ Gabapentin Capsule 400 mg. Give 1 capsule by mouth 3 times a day for neuropathy pain give with 800 mg to equal 1200 mg. Scheduled for 8:00 PM. The medication was administered on 12/25/24 at 10:22 PM, 12/28/24 at 9:11 PM, 12/30/24 at 9:09 PM, 12/31/24 at 9:54 PM, and 1/12/25 at 9:25 PM.<br><br>On 1/14/25 at 3:00 PM, Surveyor interviewed Director of Nursing (DON)-B who verified the above medications for R4 were administered late in December 2024 and January 2025. DON-B confirmed the facility's medication administration timeframe is one hour before or one hour after the medication's scheduled time. DON-B indicated if a resident was refusing medications at the scheduled time, the nurse should update the resident's physician and ask to change to a scheduled time more appropriate for the resident.<br><br>42423<br><br>2. On 1/14/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including fracture of unspecified part of neck of left femur, type 2 diabetes, Crohn's disease of small intestine without complications, gout, and myoneural disorder. R10's MDS assessment, dated 12/29/24, had a BIMS score of 15 out of 15 which indicated R10 was not cognitively impaired.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/14/25 at 11:15 AM, Surveyor interviewed R10 who indicated R10 had pain issues and contacted a physician to get medication because staff did not listen to R10's requests for pain medication. R10 indicated R10 should not have had to contact a physician, however, R10 told multiple nurses about the pain and nothing was done. R10 indicated nursing staff were overworked and understaffed but that did not mean residents should go without medication. R10 indicated pain medication was now scheduled since R10 had to wait to receive as-needed (PRN) pain medication. R10 indicated Certified Nursing Assistants (CNAs) turned R10's call light off when R10 requested pain medication and said they would tell the nurse but the nurse said they did not receive the message. R10 indicated R10 received scheduled pain medication yesterday around supper time and should have received another dose between midnight and 1:00 AM, however, the medication was not administered. R10 stated R10 was in more pain when R10 did not receive the medication because the earlier dose had worn off. R10 did not receive the next dose until between 5:00 and 6:00 AM and had a pain level of 7 out of 10. R10 indicated if R10 laid still R10 was fine, but when R10 moved the pain was excruciating. R10 indicated an ideal pain level was 2 to 3 and preferred R10's medications were administered timely.<br><br>R10 had a physician's order for Tramadol HCl Oral Tablet, Give 50 mg by mouth every 6 hours for pain for two weeks. R10's MAR indicated R10 did not receive the midnight dose of tramadol on the 1/13/25 NOC shift.<br><br>A progress note, written by Licensed Practical Nurse (LPN)-E at 1:40 AM on 1/14/25, indicated it was too close to the next scheduled dose time to administer R10's medication. A medication administration report indicated R10 received a 6:00 PM dose of tramadol on 1/13/25 but did not receive another dose until 5:07 AM on 1/14/25.<br><br>On 1/14/25 at 3:03 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-V who confirmed R10's NOC shift dose of tramadol was not administered by LPN-E because it was too close to the AM administration time.<br><br>3. On 1/14/25 at 11:20 AM, Surveyor was interviewing R10 when LPN-L entered R10's room with a cup of medication and a cup of water. LPN-L set both cups on R10's table and left the room without watching R10 take the medication. R10 indicated nurses drop off medication at times and do not wait until R10 takes the medication. R10 stated, I don't even really know what I am taking. They just bring it in, set down the cup, and say here's your medicine. I really only care about the pain medications. R10 stated R10 would rather risk addiction with stronger medication instead of sit there in pain. R10 indicated nurses were supposed to observe R10 take R10's medication before leaving the room and stated, I could easily sit on the narcotic pill and save 3 or 4 of them and then take them all at once or when I want, but I don't. Surveyor observed R10 count the pills in the cup, shake the pills, and then swallow them.<br><br>R10's MAR contained orders for magnesium oxide, tramadol 50 mg for pain, and Tylenol 500 mg (2 tablets) that were administered to R10 by LPN-L at 11:20 AM.<br><br>On 1/14/25 at 1:27 PM, Surveyor interviewed LPN-L who indicated LPN-L tries to watch R10 take medication because of the potential for abuse of tramadol. LPN-L confirmed R10 did not have a self-administration of medication assessment or a physician's order to self-administer medication.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/4/25 at 1:38 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed R10 did not have a self-administration of medication assessment or order. NHA-A confirmed nurses should not leave medication with R10 without ensuring the medications are taken. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0758<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793<br><br>Based on staff interview and record review, the facility did not ensure adequate monitoring and administration for 1 resident (R) (R7) of 3 sampled residents who received psychotropic medication.<br><br>R7 had an order for clozapine 25 milligrams (mg) twice daily (BID) for psychosis related to Parkinson's disease and a weekly complete blood count (CBC) with differential (diff) for monitoring. On 11/19/24, staff did not ensure the correct lab was drawn. R7 did not receive clozapine from 11/23/24 to 11/26/24 and was sent to the emergency room (ER) on 11/26/24 for symptoms of psychosis.<br><br>Findings include:<br><br>The facility's Laboratory, Radiology, and Other Diagnostic Services policy, dated 1/11/21, indicates the facility will provide or obtain laboratory services to meet the needs of its residents and will be responsible for quality and timeliness of the services.<br><br>From 1/13/25 to 1/14/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, anxiety, hallucinations, and malnutrition. R7's most recent Minimum Data Set (MDS) assessment, dated 12/22/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R7 had moderate cognitive impairment. R7 had an activated Power of Attorney for Healthcare (POAHC) since admission.<br><br>Surveyor reviewed R7's physician orders and noted the following:<br><br>~ Clozapine 25 mg 1 tablet by mouth two times per day for psychosis for Parkinson's disease (start date 9/16/24)<br><br>~ Weekly CBC with diff for monitoring while on clozapine, one time a day every Tuesday (start date 10/1/24)<br><br>Surveyor reviewed R7's November 2024 Treatment Administration Record (TAR) and noted R7's CBC with diff lab was not signed out on 11/19/24. Surveyor reviewed R7's laboratory results for November 2024 and noted on 11/19/24, Registered Nurse (RN)-I completed a lab form and checked the box for a CBC lab draw rather than a CBC with diff. Surveyor reviewed the lab results sheet and verified the lab ran a CBC without differential.<br><br>Surveyor reviewed R7's November 2024 Medication Administration Record (MAR) and noted R7's clozapine was not administered from 11/23/24 through 11/26/24 for a total of 8 missed doses. Nursing staff documented the medication was on hold/see progress notes. Surveyor reviewed R7's progress notes from 11/23/24 through 11/26/24 and noted several instances where the facility documented they were waiting for a refill from pharmacy. A progress note, dated 11/24/24, indicated the physician would not re-order R7's clozapine until a CBC with differential was drawn.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525315 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Care Center of Weyauwega | 717 E Alfred St<br>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 0758<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An ER visit note indicated on 11/26/24 at approximately 1:30 AM, facility staff observed R7 standing on R7's bed, reaching up the wall, and appearing to have ingested an unknown amount of aloe vera lotion. R7 had excessive drooling and frothing from the mouth. R7 was sent to the ER and was noted to be confused and anxious. R7 received intravenous glycopyrronium bromide (a medication used to treat ulcers, excessive drooling/sweating, and chronic obstructive pulmonary disorder (COPD) symptoms). R7 returned to the facility at approximately 5:00 AM on 11/26/24.<br><br>On 1/14/25 at 9:55 AM, Surveyor interviewed RN-I regarding R7's lab draw. RN-I indicated RN-I thought the order stated a CBC without differential and was not aware that the incorrect lab was drawn. RN-I did not recall receiving education about ensuring labs are drawn per the physician's order.<br><br>On 1/14/25 at 12:07 PM, Surveyor interviewed Consultant Pharmacist (CP)-W regarding clozapine and lab monitoring. CP-W verified after 36-48 hours the medication would have been out of R7's system which would increase the likelihood of psychosis symptoms.<br><br>On 1/14/25 at 12:41 PM, Surveyor interviewed Neurology RN-N regarding R7's missed lab and medication. RN-N stated the Neurologist was not aware that R7 had missed 8 doses of clozapine. RN-N verified weekly monitoring was required for clozapine due to potential blood cell abnormalities. RN-N indicated a regular CBC was not adequate to monitor for that side effect. RN-N verified missing 8 doses of clozapine would greatly increase the likelihood of psychosis symptoms. RN-N also indicated R7 did not have a history of ingesting non-food items or other psychosis symptoms since starting clozapine.<br><br>On 1/14/25 at 1:20 PM, Surveyor interviewed RN-M regarding R7's missed clozapine and change in behavior. RN-M verified R7 did not have a history of ingesting non-food items or climbing on R7's bed. RN-M verified R7's clozapine had been on hold from the pharmacy due to an incorrect lab draw on 11/19/24.<br><br>On 1/14/25 at 1:31 PM, Surveyor interviewed CNA-O regarding R7's behaviors. CNA-O verified CNA-O worked regularly with R7 and had never observed R7 try to ingest non-food items or climb on R7's bed.<br><br>On 1/14/25 at 1:43 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding R7's missed clozapine and incorrect lab draw. NHA-A verified an incorrect lab was drawn on 11/19/24 and the facility was unable to re-order R7's clozapine until the correct lab was drawn. |