

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Crossroads Care Center of Weyauwega		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</p> <p>Based on staff interview and record review, the facility did not provide timely access to a medical record for 1 resident (R) (R2) of 1 sampled resident.</p> <p>R2 requested a copy of R2's medical record in writing on 1/3/25. R2's medical record was mailed on 1/28/25 (25 days later) which was not in accordance with the facility's policy that indicated the facility would provide a copy within 7 days.</p> <p>Findings include:</p> <p>The facility's Medical Records policy, dated 1/11/21, indicates: It is the policy of the facility to maintain medical records in accordance with state and federal regulations .8. Unless expressly prohibited by a legally competent resident, the facility will furnish to the spouse, guardian, surrogate, proxy, or attorney of a current resident, within 7 working days after receipt of a written request, or a former resident, within 10 working days after receipt of a written request, a copy of that resident's records which are in the possession of the facility.</p> <p>On 2/18/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction, generalized anxiety disorder, and pulmonary embolism. R2's Minimum Data Set (MDS) assessment, dated 1/1/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 did not have impaired cognition. R2 was responsible for R2's healthcare decisions and discharged from the facility on 1/6/25.</p> <p>R2's medical record contained an Authorization for Release of Medical Record Information form signed by R2 on 1/3/25 that requested a copy of R2's medical record.</p> <p>A progress note, dated 1/28/25, indicated R2's medical record request was fulfilled and R2's records were sent via mail.</p> <p>On 2/18/25 at 2:09 PM, Surveyor interviewed Medical Records Coordinator (MRC)-C who confirmed a copy of R2's medical record was mailed on 1/28/25. MRC-C stated the facility does not have a designated number of days in which they must fulfill a records request. MRC-C stated it can take a month or more due to all the records MRC-C has to sort through and administration may need to review the information first. MRC-C stated MRC-C did not have direct communication with R2 or R2's family regarding the records request.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/18/25 at 2:31 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated NHA-A believed records requests should be fulfilled within 10 days.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51043</p> <p>Based on staff interview and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 2 residents (R) (R5 and R6) of 3 sampled residents.</p> <p>R5 had a suprapubic catheter and was on enhanced barrier precautions (EBP). On 2/18/25, Certified Nursing Assistant (CNA)-D did not wear a gown during personal hygiene and catheter care for R5.</p> <p>On 2/18/25, CNA-E did not complete hand hygiene or change gloves appropriately during an observation of care for R6.</p> <p>Findings include:</p> <p>The facility's Bathing Policy, revised 12/12/24, indicates: .9. Wash back, buttocks and genitalia. 10. Change water during bath if necessary. 11. Remove gloves, complete hand hygiene, and apply new gloves .</p> <p>The facility's Infection Control-Hand Hygiene policy, revised 7/7/23, indicates: .Alcohol-based hand sanitizer is appropriate for decontaminating hands .e. When moving from a contaminated body site to a clean body site during resident care .</p> <p>The facility's Enhanced Barrier Precautions (EBP) policy, dated 3/25/24, indicates: .Gown and glove use during high-contact resident care activities .will be initiated for residents with .indwelling medical devices (e.g. , central lines, urinary catheters .) .Personal protective equipment (PPE), such as gowns and gloves for enhanced barrier precautions is only necessary when performing high-contact care activities .High-contact resident care activities include .g. Device care or use: central lines, urinary catheters .</p> <p>1. On 2/18/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes, obstructive and reflux uropathy, and retention of urine. R5's Minimum Data Set (MDS) assessment, dated 12/27/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition.</p> <p>On 2/18/25 at 8:47 AM, Surveyor observed CNA-D enter R5's room and don gloves. CNA-D cleansed R5's peri-area and suprapubic catheter. CNA-D then removed gloves, completed hand hygiene, donned clean gloves, and assisted 5 with getting dressed. CNA-D then removed gloves, completed hand hygiene, and exited the room. Surveyor noted CNA-D did not wear a gown during high-contact care for R5. When Surveyor asked CNA-D if the EBP sign posted outside R5's room would cause CNA-D to alter the PPE CNA-D wore during cares for R5, CNA-D indicated no.</p> <p>On 2/18/25 at 1:51 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated CNA-D should have worn a gown during high-contact cares for R5. Infection Preventionist (IP)-G concurred with DON-B.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 2/18/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including peripheral vascular disease (PVD), Fournier gangrene (flesh-eating disease), type 2 diabetes, carrier of carbapenem-resistant Acinetobacter baumannii, neuromuscular dysfunction of bladder, and resistance to vancomycin. R6's MDS assessment, dated 11/7/24, had a BIMS score of 15 out of 15 which indicated R6 had intact cognition.</p> <p>On 2/18/25 at 9:03 AM, Surveyor observed CNA-E and CNA-F provide a bed bath. R6 had a urinary catheter and a sign outside R6's door that indicated R6 was on EBP. CNA-E and CNA-F completed hand hygiene, donned gowns and gloves, and entered R6's room. CNA-E and CNA-F cleansed R6's hair and upper body and then cleansed R6's lower body and peri-area. CNA-E also put lotion on R6's legs. CNA-F left the room to retrieve a full body lift with a scale which CNA-E and CNA-F used to weigh R6. CNA-E and CNA-F then changed R6's bottom sheet and then lowered R6 onto the bed. CNA-F used a walkie talkie to ask staff to bring wipes to R6's room. CNA-E then wiped stool from R6's buttocks and applied barrier cream. CNA-E and CNA-F repositioned R6 in bed, covered R6 with a sheet and comforter, and put away supplies. CNA-E and CNA-F then removed gowns and gloves, completed hand hygiene, and exited R6's room. Surveyor interviewed CNA-E immediately following the observation. CNA-E indicated CNA-E should have removed gloves, completed hand hygiene, and donned clean gloves prior to putting barrier cream on R6.</p> <p>On 2/18/25 at 1:51 PM, Surveyor interviewed DON-B who indicated CNA-E should have removed gloves, completed hand hygiene, and donned clean gloves prior to putting barrier cream on R6. IP-G concurred with DON-B.</p>		