

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 04/17/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</p> <p>Based on observation, staff and resident interview, and record review, the facility did not ensure the appropriate care and treatment was provided for 2 residents (R) (R53 and R44) of 5 residents reviewed for wound care.</p> <p>R53 was admitted to the facility with multiple wounds. The facility did not complete timely skin assessments or wound care for R53.</p> <p>The facility did not ensure R44 had a treatment order for an open area on R44's left lower shin and received timely wound care.</p> <p>Findings include:</p> <p>The facility's Wound Management-Clean Dressing Change policy, dated 4/11/11, indicates: It is the facility's policy to ensure dressing changes in accordance with state and federal regulations and national guidelines . 1) Verify and review the physician's order for the procedure .26) Document the completion of the dressing change on the treatment record.</p> <p>1. From 4/7/25 to 4/10/25, Surveyor reviewed R53's medical record. R53 was admitted to the facility on [DATE] and had diagnoses including sepsis and type 2 diabetes. R53's Minimum Data Set (MDS) assessment, dated 3/25/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R53 was not cognitively impaired. R53 was responsible for R53's medical decisions and discharged from the facility on 3/25/25.</p> <p>On 4/8/25 at 10:38 AM, Surveyor interviewed R53 via phone. R53 indicated staff did not complete wound care for R53 when R53 resided at the facility. R53 indicated R53 had foot and lower leg wounds and spoke with staff regarding the wounds. R53 stated staff did not change R53's dressing because they did not have orders.</p> <p>A Braden Scale for Predicting Pressure Sore Risk assessment, dated 3/20/25, had a score of 17 out of 23 which indicated R53 was at risk for pressure injuries.</p> <p>A hospital discharge summary, dated 3/20/25, stated R53's primary diagnosis was septic shock. R53 had a superficial ulcer on the left calf, a chronic wound/ulcer on the right great toe with erythema in the right second toe, and minimal erythema in the left lower extremity.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Additional hospital records faxed to the facility on [DATE] stated R53 had a diagnosis of diabetic ulcer of right great toe and indicated the following wounds were noted during R53's hospitalization :</p> <ul style="list-style-type: none"> ~ Wound to anterior right foot D1 great toe (dated 3/10/25) ~ Wound to anterior right foot D2 second toe (dated 3/10/25) ~ Wound to left lower posterior proximal leg (dated 3/10/25) ~ Skin tear wound to anterior right knee (dated 3/17/25) ~ Healed wound to anterior left foot D2 second toe, scabbed (dated 3/15/25) ~ Healed wound to left posterior heel, scabbed (dated 3/15/25) <p>An Admission Data Collection and Baseline Care Plan Tool, dated 3/21/25, stated R53 had an active infection, received antibiotics at the time of admission, and had edema in the bilateral lower extremities. The assessment summary stated R53 had suspected cellulitis/wound infection in the right lower extremity. A skin map for R53 did not contain any markings.</p> <p>An Advance Practice Nurse Prescriber (APNP) note, dated 3/21/25, contained an instruction to ensure wound care saw R53 for multiple scabbed areas noted by the APNP.</p> <p>A Skin Impairment/Wound Evaluation, dated 3/22/25, indicated treatment was needed for pressure ulcer/injury care with applications of ointments/medications other than to feet and included the following skin impairments:</p> <ul style="list-style-type: none"> ~ Superficial open area to left calf that measured 2 centimeters (cm) (length) x 2 cm (width) x 0.1 cm (depth) ~ Eschar to left heel that measured 2 cm x 0.2 cm ~ Open area to outer aspect of left big toe that measured 3 cm x 2 cm x 0.3 cm ~ Skin abrasion to right leg under knee that measured 4 cm x 2 cm x 0.1 cm <p>R53's Treatment Administration Record (TAR) contained the following orders:</p> <ul style="list-style-type: none"> ~ Wound care left thigh: Cleanse with wound cleanser; pat dry; apply collagen followed by Aquacel covered with bordered foam; every day and as needed for wound care (Start date: 3/24/25) ~ Wound care left thigh: Cleanse with wound cleanser; pat dry, apply collagen followed by Aquacel covered with bordered foam; every day and as needed; every day shift for wound healing (Start date: 3/25/25) ~ Wound care right big toe: Cleanse with wound cleanser; apply collagen followed by Aquacel with bordered foam; every day and as needed for wound care (Start date: 3/24/25) <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/25 at 2:46 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A stated R53 was admitted to the facility for therapy and wound care. NHA-A acknowledged R53 was not initially admitted with wound care orders from the hospital. DON-B confirmed R53 had a primary diagnosis of sepsis and a possible wound infection. NHA-A stated the facility's process is to complete a skin assessment upon admission and request orders from the physician. NHA-A stated a Registered Nurse (RN) or wound care certified nurse can initiate orders pending physician orders. DON-B confirmed R53 was admitted on [DATE] but the facility did not receive wound care orders until 3/24/25. DON-B confirmed R53 was transferred to the hospital on the morning of 3/25/25 and confirmed R53 did not receive wound care while at the facility. NHA-A acknowledged R53's skin assessment was not completed timely or accurately and stated skin assessments should ideally be completed within 24 hours of admission.</p> <p>50467</p> <p>2. From 4/7/25 to 4/10/25, Surveyor reviewed R44's medical record. R44 was admitted to the facility on [DATE] and had diagnoses including acute post procedural pain, polyneuropathy, diabetes, right above-the-knee amputation, and muscle weakness. R44's MDS assessment, dated 3/9/25, had a BIMS score of 11 out of 15 which indicated R44 had moderate cognitive impairment.</p> <p>On 4/7/25 at 11:42 AM, Surveyor interviewed R44 who indicated R44 had a sore on the left leg. R44 was not sure why R44 had a sore and indicated R44's leg was bleeding when R44 woke up. Surveyor observed a silicone border dressing on R44's left lower shin with a dime-size shadow on the right lower corner. The dressing was not initialed or dated. R44 indicated staff changed R44's dressing once in a while.</p> <p>R44's medical record did not contain an order for a left lower leg dressing and did not indicate why R44 had a dressing on the left lower shin.</p> <p>A Braden Scale assessment, dated 3/15/25, had a score of 16 out of 23 which indicated R44 was at mild risk for skin break down.</p> <p>Skin checks in R44's medical record, dated 3/16/25, 3/24/25, 3/27/25, and 4/1/25, indicated R44 did not have any skin impairments.</p> <p>A Nurse Practitioner (NP) note, dated 4/7/25 at 11:15 AM, indicated R44 had a dressing on the left lower shin with stasis changes and trace edema and the NP would consult with wound care. The note contained an order to continue ketoconazole 2% cream and ammonium lactate 12% lotion to the left lower extremity.</p> <p>On 4/10/25 at 12:02 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who indicated R44 did not have open areas or a dressing on R44's left shin area but had cream that was applied to the left leg. LPN-L indicated R44 was anxious related to a right above-the-knee amputation on 2/28/25 and was afraid of losing R44's left leg also.</p> <p>On 4/10/25 at 12:04 PM, Surveyor interviewed R44 who showed Surveyor that R44's dressing was still in place. R44 indicated again that staff applied the dressing a while ago when the area was bleeding. Surveyor again observed the dressing which was not initialed or dated and had a dime-size shadow on the right lower corner.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/10/25 at 12:51 AM, Surveyor interviewed LPN-E who was the facility's wound care nurse. LPN-E confirmed there was no documentation in R44's medical record related to the left shin. LPN-E indicated LPN-E was scheduled to see R44 that day based on the notification LPN-E received on 4/9/25. LPN-E indicated nursing staff should date and initial dressings following wound care and a nursing order should be completed if a dressing is applied to a new area of concern.</p> <p>On 4/10/25 at approximately 2:00 PM, Surveyor interviewed LPN-E who confirmed LPN-E assessed R44's left shin which had an open area that measured 1.5 cm x 1.0 cm with hyper granulation in the wound base and scant serosanguineous drainage. LPN-E confirmed the wound was not placed on the March or April wound boards for LPN-E to review. LPN-E indicated a treatment was now in place for R44.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</p> <p>Based on staff and resident interview and record review, the facility did not provide the necessary care and services to promote healing and/or prevent pressure injuries from developing for 1 resident (R) (R53) of 5 sampled residents.</p> <p>R53 was admitted to the facility with a pressure injury on the right buttock. The facility did not ensure thorough, accurate, and timely skin assessments were completed and did not ensure a treatment was provided.</p> <p>Findings include:</p> <p>The facility's Wound Management-Clean Dressing Change policy, dated 4/11/11, indicates: It is the facility's policy to ensure dressing changes in accordance with state and federal regulations and national guidelines . 1) Verify and review the physician's order for the procedure .26) Document the completion of the dressing change on the treatment record.</p> <p>From 4/7/25 to 4/10/25, Surveyor reviewed R53 medical record. R53 was admitted to the facility on [DATE] and had diagnoses including sepsis and type 2 diabetes. R53's Minimum Data Set (MDS) assessment, dated 3/25/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R53 was not cognitively impaired. R53 was responsible for R53's medical decisions and discharged from the facility on 3/25/25.</p> <p>On 4/8/25 at 10:38 AM, Surveyor interviewed R53 via phone. R53 indicated staff did not provide wound care when R53 resided at the facility. R53 indicated R53 had a pressure injury on the right buttock and spoke with staff regarding the wound. R53 stated staff did not change R53's dressing because they did not have an order.</p> <p>A Hospital Discharge Summary, dated 3/20/25, indicated R53's primary diagnosis was septic shock. Additional hospital records faxed to the facility on [DATE] indicated R53 had a pressure injury on the buttock which was first assessed on 3/16/25.</p> <p>A Braden Scale for Predicting Pressure Sore Risk assessment, dated 3/20/25, had a score of 17 out of 23 which indicated R53 was at risk for pressure injuries.</p> <p>An Admission Data Collection and Baseline Care Plan Tool, dated 3/21/25, indicated R53 had an active infection and received antibiotics upon admission. The assessment indicated R53 had edema in the bilateral lower extremities and a suspected cellulitis/wound infection in the right lower extremity. A skin map for R53 contained no markings and indicated R53 did not have any skin issues.</p> <p>A care plan, dated 3/21/25, indicated R53 had potential/actual impairment to skin integrity. On 3/24/25, revisions to the care plan indicated R53 had a pressure injury on the right upper buttock. An additional care plan, initiated on 3/24/25, indicated R53 had a pressure ulcer or potential for pressure ulcer development to buttocks related to immobility. The care plan contained interventions (dated 3/21/25) for a pressure relieving air mattress and to turn/position as necessary. The care plan did not mention a pressure injury on R53's right hip.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Advance Practice Nurse Prescriber (APNP) note, dated 3/21/25, contained an instruction to ensure wound care saw R53 for multiple scabbed areas noted by the APNP.</p> <p>A Skin Impairment/Wound Evaluation, dated 3/22/25, indicated treatment was needed for pressure ulcer/injury care with applications of ointments/medications other than to feet and indicated R53 had 5 skin issues including a stage 1 pressure injury on the right upper buttock that measured 7 centimeters (cm) (length) x 3 cm (width).</p> <p>R53's Treatment Administration Record (TAR) contained the following orders:</p> <ul style="list-style-type: none"> ~ Right hip stage 1 pressure ulcer: Place bordered foam for protection every 3 days as needed for wound care (Start date: 3/24/25) ~ Right hip stage 1 pressure ulcer: Place bordered foam for protection every 3 days. Every day shift every 3 days for wound care (Start date: 3/25/25) ~ Wound care right buttocks: Apply barrier cream with cares and as needed (Start date: 3/24/25) ~ Wound care right buttocks: Apply barrier cream with cares and as needed. Every shift. (Start date: 3/24/25) <p>Surveyor reviewed R53's Skin Impairment/Wound Evaluation and TAR. Surveyor noted R53 had wound care orders for both a stage 1 pressure injury on the right hip and right buttock. R53's wound evaluation did not include a stage 1 pressure injury on the right hip.</p> <p>On 4/9/25 at 2:46 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A stated R53 was admitted to the facility for therapy and wound care. NHA-A acknowledged R53 was not admitted with wound care orders from the hospital. DON-B confirmed R53 had a primary diagnosis of sepsis and possible wound infection. NHA-A stated staff should complete a skin assessment upon admission and request orders from the physician. NHA-A stated a Registered Nurse (RN) or wound care certified nurse can initiate orders pending physician orders. DON-B confirmed R53 was admitted on [DATE] and the facility did not receive wound care orders until 3/24/25. DON-B confirmed R53 was transferred to the hospital on the morning of 3/25/25 and did not receive wound care while at the facility. NHA-A acknowledged R53's skin assessment was not completed timely or accurately and stated skin assessments should ideally be completed within 24 hours of admission.</p> <p>On 4/10/25 at 1:35 PM, Surveyor interviewed DON-B related to R53's right hip wound. DON-B indicated the wound might be the same wound that was on R53's right buttock which was high on the buttock. DON-B acknowledged the right hip wound was not included on the Skin Impairment/Wound Evaluation completed on 3/22/25.</p> <p>On 4/10/25 at 1:56 PM, Surveyor interviewed RN-O who completed R53's wound evaluation on 3/22/25 and indicated all 6 wounds were assessed. Surveyor indicated 5 wounds were listed on the 3/22/25 wound evaluation but the stage 1 pressure injury on R53's right hip was not listed. When Surveyor asked about the origin of R53's right hip wound, RN-O stated RN-O might have documented the wound as a buttock wound because the wound was located in between the buttock and the hip.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility was unable to provide evidence regarding the number of pressure injuries R53 had while in the facility.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>48794</p> <p>Based on observation, staff and resident interview, and record review, the facility did not ensure the provision of sufficient nursing staff to meet residents' needs. This practice had the potential to affect more than 4 of the 49 residents residing in the facility.</p> <p>R24, R29, R44, R3, and R53 expressed concerns with staffing and call light response times. In addition, R24's call light was activated for 1 hour and 19 minutes on 4/9/25. Two other residents' call lights were activated for 35 minutes and 55 minutes.</p> <p>On 4/8/25, Certified Nursing Assistant (CNA)-DD was the only staff present in the dining room. R23 and R402 require feeding assistance and had to wait until all other residents were served. R41 asked for water twice but was not provided water.</p> <p>The facility did not ensure sufficient staffing levels were maintained to meet residents' needs in accordance with the Facility Assessment and resident acuity.</p> <p>Findings include:</p> <p>1. On 4/7/25 at 10:30 AM, Surveyor interviewed R24 who indicated R24 had waited up to 3 hours for staff to respond to R24's call light. R24 indicated staff are not efficient and it is not acceptable to wait 2 to 3 hours to use a urinal. R24 indicated R24 takes a water pill and holding R24's urine for 3 hours is too long.</p> <p>On 4/7/25 at 11:00 AM, Surveyor interviewed R29 who indicated it can take staff 2 to 3 hours to answer a call light.</p> <p>On 4/7/25 at 11:42 AM, Surveyor interviewed R44 who indicated staff might respond to a call light timely, however, they turn the call light off and state they will come back later because they are busy. R44 indicated one staff on the NOC shift says they will return but does not and then gets upset when R44 has a wet bed and a full urinal. R44 indicated there is also a staff on the NOC shift who gets upset because R44 can not use the toilet. R44 indicated R44 is unable to use the toilet due to a recent right above-the-knee amputation and has fallen twice already. R44 indicated R44 needs assistance with toileting.</p> <p>On 4/7/25 at 12:39 PM, Surveyor interviewed R3 who indicated CNAs have told R3 to soil R3's self because they do not have enough staff to get R3 up. R3 stated staff let R3 sit in a soiled brief for an hour. R3 indicated R3 gets so upset that R3 pulls the brief off and throws it on the floor so R3 does not have to sit in urine. R3 indicated R3 was told multiple times that R3 has a pad and should just wet R3's self.</p> <p>On 4/8/25 at 10:38 AM, Surveyor interviewed R53 via phone. R53 stated staffing was terrible at the facility, especially on the NOC shift. R53 stated one night R53 had diarrhea and activated the call light for assistance. R53 stated it took staff an hour and a half for staff to respond. R53 stated R53 was incontinent due to the long response time and felt humiliated.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/9/25 at 9:50 AM, Surveyor observed call light response times and noted 3 residents had call lights activated. The wait times were 35 minutes, 55 minutes, and 1 hour and 19 minutes. At 11:09 AM, Surveyor observed CNA-W exit R24's room. When Surveyor asked if R24's needs had been met and indicated R24's call light had been on for 1 hour and 19 minutes, CNA-W indicated R24's needs had been met but R24 was still waiting for DON-B and wanted to keep the call light on until DON-B arrived.</p> <p>49010</p> <p>2. On 4/8/25 at 7:48 AM, Surveyor observed breakfast in the main dining room and noted CNA-DD was the only staff in the dining room with 7 residents. Surveyor observed CNA-DD pour drinks, offer napkins, prepare and deliver food, and assist with condiments. Surveyor noted R23 and R402 were seated at different tables and needed assistance with eating. Surveyor noted R23 and R402 waited until the rest of the residents were served and assisted before R23 and R402 received assistance with their meals. Since CNA-DD was only able to feed 1 resident at a time, R23 waited for assistance until CNA-DD finished feeding R402. R23 and R402's food was not kept warm while they waited.</p> <p>On 4/8/25 at 8:07 AM, Surveyor observed R41 ask twice for water and state R41 would really like some. R41 did not receive water because CNA-DD was assisting other residents.</p> <p>On 4/8/25 at 8:14 AM, Surveyor interviewed R41 who indicated the facility does not have enough staff. R41 indicated food is cold by the time it is delivered. R41 indicated R41 always has to wait for things and sometimes does not get them.</p> <p>On 4/8/25 at 8:26 AM, Surveyor interviewed CNA-DD who indicated CNA-DD worked alone because no other staff came to the dining room. CNA-DD indicated another CNA was scheduled to be in the dining room but most likely had to stay on the unit and provide care. CNA-DD indicated when CNA-DD walked by the dining room, CNA-DD saw residents in the dining room and food on the cart waiting to be delivered so CNA-DD started assisting residents. CNA-DD indicated there are often not enough staff in the dining room because CNAs are supposed to cover the dining room in addition to resident units. CNA-DD indicated residents have to wait for assistance when there is only 1 staff in the dining room.</p> <p>50467</p> <p>3. On 4/8/25, Surveyor reviewed the Facility Assessment (last revised 8/1/24). The Assessment indicated there should be 5 to 9 licensed nurses and 8 to 15 CNAs providing direct care per day.</p> <p>On 4/9/25 at 11:43 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A needed to revise the Facility Assessment because the facility currently scheduled nursing staff according to resident acuity. When asked about staffing numbers, NHA-A indicated for a census of 45-52 residents there should be:</p> <p>~ Licensed staff: 3 on the AM shift; 2 to 3 on the PM shift; 1 on the NOC shift</p> <p>~ CNAs: 4 to 6 on the AM and PM shifts; 2 to 3 on the NOC shift</p> <p>The information provided by NHA-A indicated the staffing hour ratio (staffing hours per day divided by the census) should be between 2.84 and 3.38.</p> <p>(continued on next page)</p>		

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 04/17/2025
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor reviewed the daily nursing staff schedules and census for 10/3/24 to 10/6/24, 11/28/24 to 12/1/24, and 12/26/24 to 12/29/24 and noted the following:</p> <ul style="list-style-type: none"> ~ The 10/5/24 schedule contained a census of 51 residents. The staffing hour ratio was 2.80. ~ The 11/29/24 schedule contained a census of 52 residents. The schedule indicated there was only 1 CNA and 1 Licensed Practical Nurse (LPN) on the NOC shift (10:00 PM to 6:00 AM) from 11:00 PM to 2:00 AM. The staffing hour ratio was 2.55. ~ The 12/1/24 schedule contained a census of 52 residents. The staffing hour ratio was 2.82. ~ The 12/26/24 schedule contained a census of 54 residents. The staffing hour ratio was 2.51. <p>On 4/9/25 at 11:43 AM, Surveyor interviewed NHA-A confirmed there were only 2 staff for 52 residents on 11/29/24 which was below staffing levels and resident acuity.</p>		