STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525315	A. Building B. Wing	04/17/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50479 Based on staff and resident representative interview and record review, the facility did not ensure an Advance Directive was followed for 1 resident (R) (R37) of 20 sampled residents. R37 had an activated Power of Attorney for Healthcare (POAHC) when R37 returned from the hospital and signed multiple consent forms on [DATE]. The facility did not request and obtain a capacity evaluation when R37's cognition improved after recovering from sepsis. In addition, R37's POAHC was not notified until [DATE] that R37 was deemed to b incapacitated on [DATE]. Findings include: From [DATE] to [DATE], Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] and had diagnoses including depression, malnutrition, type two diabetes, and obstructive uropathy. R37's most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated R37 was not cognitively impaired. R37 was hospitalized on [DATE] for urinary sepsis and returned to the facility on [DATE]. R37's care plan, with a target date of [DATE], indicated R37 had an activated POAHC which was added to R37's care plan on [DATE]. Surveyor reviewed R37's Advance Directive paperwork and noted a Statement of Incapacity, dated [DATE], that was signed by two medical providers and indicated R37 was incapacitated as defined by Wisconsin Statute 155.01(8). R37's POAHC paperwork, dated [DATE], designated POAHC-BB as R37's healthcare agent; however, R37's medical record indicated R37 was R37's own decision maker. R37's medical record contained multiple consents signed by R37 on [DATE], including consent for treatment, consent for cardiopulmonary resuscitation (CPR), consent to obtain a COVID-19 vaccine, consent to be screened for multidrug-resistant organisms (MDROs), and consent to share a common bathroom. On [DATE] at 8:42 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who indicated LPN-C was the manager for R37's unit. LPN-C indicated the consents signed by R37 on [DATE] were part of the facility's admission packet. LPN-C indicated the nurse who completes the admission pack is responsible for signing consents with the resident and should review the resident's Advance Directive paperwork prior. LPN-C confirmed a resident's POAHC should signs consents if the resident's POAHC is activated. LPN-C was unsure when an incapacitated resident should be reevaluated for competence and indicated the resident's healthcare provider is responsible for deciding if a resident should be reevaluated for competency. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:04 PM, Surveyor interviewed POAHC-BB who indicated the facility notified POAHC-BB on the morning of [DATE] that R37's POAHC had been activated. The facility requested POAHC-BB come to the facility to sign consents for R37. On [DATE] at 12:39 PM, Surveyor interviewed Social Services Director (SSD)-D who indicated R37's POAHC and Statement of Incapacity were included in hospital discharge paperwork when R37 was readmitted to the facility on [DATE]. SSD-D was not aware R37 had established a POAHC in 2018 and was not aware that R37's POAHC had been activated. SSD-D indicated SSD-D had multiple conversations with POAHC-BB about R37's plan of care since R37 was admitted . SSD-D indicated during SSD-D's meetings with POAHC-BB, they were both unaware that R37's POAHC had been activated. On [DATE] at 3:35 PM, Surveyor interviewed Medical Records Nurse (MRN)-EE who indicated the nurse who completes a resident's admission paperwork should review the resident's hospital discharge paperwork. MRN-EE found R37's POAHC and Statement of Incapacity when MRN-EE scanned R37's hospital discharge paperwork into R37's medical record. MRN-EE indicated MRN-EE notified LPN-C of R37's Statement of Incapacity on [DATE].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure Preadmission Screening and Resident Review (PASRR) requirements were met for 2 residents (R) (R9 and R19) of 6 sampled residents. R9's PASRR Level I Screen indicated R9 had a mental illness (MI) and a 30-day hospital discharge exemption. The facility did not obtain form F-20822 for R9's 30-day exemption and did not submit for a PASRR Level II Screen in a timely manner. R19's PASRR Level I Screen indicated R19 had an MI and a 30-day hospital discharge exemption. The facility did not obtain form F-20822 for R19's 30-day exemption and R19's medical record did not include a PASRR Level II Screen. Findings include: According to the State of Wisconsin Department of Health Services, PASRR is a federal requirement that all applicants to Medicaid-certified nursing facilities be assessed to determine whether they might have an intellectual disability (ID)/developmental disability (DD) and/or MI. This is called a Level I Screen. The purpose of a Level I Screen is to identify individuals whose total needs require they receive additional services for their ID/DD and/or MI. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an ID/DD and/or MI for PASRR purposes. This is a Level II Screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care. Nursing facilities may seek county exemption for applicants with ID/DD and/or MI whose stay in the facility is expected to be recuperative care or short-term, as evidenced by receipt of County Review of Nursing Home, IMD or ICF/IID Referrals (F-20822). 1. From 4/7/25 to 4/10/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had a diagnosis of bipolar disorder. R9's Minimum Data Set (MDS) assessment, dated 2/18/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R9 had moderate cognitive impairment. R9's medical record included a PASRR Level I Screen that indicated R9 had a diagnosis of a major mental disorder and a 30-day hospital discharge exemption. R9's medical record did not include County form F-20822 for the 30-day hospital exemption and did not include a PASRR Level II Screen. On 4/10/25 at 10:13 AM, Surveyor interviewed Social Services Director (SSD)-D who indicated SSD-D submitted to the county for a 30-day exemption for R9 but did not receive confirmation. SSD-D stated SSD-D submitted for a PASRR Level II Screen for R9 on 4/7/25 after Surveyor requested the information. SSD-D acknowledged a PASRR Level II Screen was not obtained in a timely manner. 2. From 4/7/25 to 4/10/25, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including adjustment disorder with depressed mood and depression. R19's MDS assessment, dated 2/9/25, had a BIMS score of 13 out of 15 which indicated R19 was not cognitively impaired. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's medical record included orders for duloxetine (an antidepressant and psychotropic medication), with an original start date of 11/1/24 and a revised date of 2/5/25, and a corresponding diagnosis of depression. R19's PASRR Level I Screen indicated R19 had an MI and did not receive psychotropic medication. R19's PASRR Level I Screen indicated R19 received duloxetine for pain. R19's PASRR Level I Screen also indicated R19 had a 30-day hospital discharge exemption. R19's medical record did not include a 30-day hospital exemption (F-20822) and did not include a PASRR Level II Screen. On 4/10/25 at 10:13 AM, Surveyor interviewed SSD-D who stated SSD-D submitted to the county for a 30-day exemption for R19 but did not receive confirmation. SSD-D also stated SSD-D submitted for a PASRR Level II Screen for R19 on 4/10/25 after Surveyor requested the information. SSD-D acknowledged a PASRR Level II Screen was not obtained in a timely manner.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 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. R53 was admitted to the facility with multiple wounds. The facility did not complete timely skin assessments or wound care for R53. 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. Findings include: 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. 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. 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. 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. 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. 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 : ~ 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) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ 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) 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. 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. 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: ~ 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 R53's Treatment Administration Record (TAR) contained the following orders: ~ 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) ~ Wound care right big toe: Cleanse with wound cleanser, apply collagen followed by Aquacel with bordered foam; every day and as needed; every day shift (Start date: 3/25/25) ~ Wound care right knee abrasion: Cleanse with wound cleanser; apply triple antibiotic cream; every day and as needed for wound care (Start date: 3/24/25) ~ Wound care right knee abrasion: Cleanse with wound cleanser; apply triple antibiotic cream; every day and as needed; every day shift for wound care (Start date: 3/25/25) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Wound care left heel: Apply Betadine to eschar area twice daily as needed (Start date: 3/24/25) ~ Wound care left heel: Apply Betadine to eschar area twice daily every day and evening shift for wound care (Start date: 3/25/25) Surveyor noted R53's wound evaluation referred to left calf and left big toe wounds, however, R53's TAR did not include treatment for the left calf or left big toe. Surveyor also noted R53's TAR included treatments for left thigh and right big toe wounds which were not mentioned on the wound evaluation. A care plan, dated 3/21/25, indicated R53 had potential/actual impairment to skin integrity. The care plan was revised on 3/24/25 and indicated R53 had an abrasion behind the right knee, eschar on the left heel, an open area on the right big toe, and an open area on the left thigh. Documentation from R53's podiatry appointment on 3/25/25 indicated R53 was seen for follow-up of a right big toe ulcer and had 3 new ulcerations, 1 on the anterior right shin, 1 on the posterior calf, and 1 on the plantar heel. R53 was recently hospitalized and did not have regular dressing changes for the wounds. The physician indicated there was a need for debridement of necrotic tissue. Office notes indicated the following: ~ Ulcer to medial aspect of right hallux that measured 1.5 cm x 1.5 cm x 0.4 cm ~ Ulcer to anterior aspect of right lower extremity up toward knee that measured 3.0 cm x 1.4 cm x 0.2 cm ~ Ulcer to posterior aspect of left calf that measured 1.6 cm x 1.1 cm x 0.2 cm ~ Ulcer to plantar aspect of left heel that measured 2.5 cm x 0.4 cm x 0.2 cm 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. 50467 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. 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. 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. 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.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50479 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 2 residents (R) (R19 and R27) of 5 sampled residents which had the potential to affect more than 4 of the 49 residents residing in the facility, including 3 residents who shared a bathroom with R19. The facility did not ensure R19 smoked cigarettes in a safe manner consistent with the facility's smoking policy. R19 smoked in R19's room with no revisions to R19's care plan to ensure the safety of R19 or other residents in the vicinity. On one occasion, a hot cigarette butt had singed trash in a garbage can in R19's bathroom. R27 exited the building unsupervised on multiple occasions. During the survey, Surveyor noted care-planned interventions (WanderGuard bracelet in place and window only partially opened) were not implemented. The facility's failure to supervise, remove smoking materials from, and ensure R19 did not smoke in the facility and it's failure to supervise and ensure the whereabouts of R27 created a finding of immediate jeopardy that began on 3/5/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 4/10/25 at 1:15 PM. The jeopardy was removed on 4/10/25, however, the deficient practice continues at a scope/severity level E (potential for no more than minimal harm/pattern) as the facility continues to implement its action plan. Findings include: Example 1 - Unsafe Smoking: The facility's Resident Smoking Policy, dated 3/30/22, indicates: All residents who smoke may only smoke in a designated smoking area. At no time is smoking permitted in the facility .Extinguished smoking materials must be placed in the appropriate receptacles .The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely .Smoking at this facility is a privilege and any non-compliance with our smoking policy may result in loss of smoking privileges while at the facility or involuntary discharge from the facility . From 4/7/25 to 4/10/25, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] for treatment of a non-healing right below-the-knee amputation stump wound. R19 had diagnoses including bilateral below-the-knee amputations, chronic obstructive pulmonary disease (COPD), type 2 diabetes, adjustment disorder with depressed mood, and anxiety. R19's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated that R19 was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R19's care plan, initiated 10/31/24, indicated R19 was a smoker and chose not to smoke in the designated smoking area. R19 stated R19 is a rule breaker and becomes easily frustrated when approached in an incorrect area (revised on 2/16/25). The care plan had a goal that R19 will not suffer injury from unsafe smoking/vaping practices through the review date (initiated 10/31/24) and contained the following interventions: Instruct R19 about smoking/vaping risk and hazards and about smoking cessation aids that are available; Instruct R19 about the facility's policy on smoking/vaping, locations, times, and safety concerns; Notify charge nurse immediately if it is suspected R19 has violated the facility's smoking policy; Observe clothing and skin for signs of cigarette burns; R19 can smoke unsupervised; R19 is able to light own cigarette and keep lighter and carton of cigarettes at bedside (all initiated 10/31/24). Numerous progress notes in R19's medical record indicated R19 had disruptive behavior, including threatening other residents and inappropriate behavior toward staff. The facility called the police department on multiple occasions because of R19's behavior. Staff documented on a weekly basis that R19 violated the facility's smoking policy and smoked outside of the designated smoking area. Surveyor noted R19's smoking care plan was not revised after numerous progress notes documented that R19 had violated the smoking policy. A progress note, dated 11/3/24, indicated R19's room had a strong odor of cigarette smoke. Staff instructed R19 not to smoke cigarettes inside the facility and to smoke in the designated smoking area. R19's care plan was not revised following the incident and a new smoking assessment was not completed. R19 had two smoking assessments completed since admission to the facility. A smoking assessment, dated 2/4/25, indicated R19 has no smoking related incidents and could smoke independently. A smoking assessment, dated 2/12/25, also indicated R19 had no smoking related incidents and could smoke independently. A progress note, dated 3/5/25, indicated staff responded to R19's room due to a strong odor of cigarette smoke. R19 initially denied smoking in R19's room but then admitted to smoking a cigarette in the room. NHA-A reviewed the smoking policy and rules with R19 and attempted to remove R19's smoking materials from the room, however, R19 would not allow NHA-A to remove the smoking materials. There was no revision to R19's care plan to ensure R19's safety or the safety of other residents. A new smoking assessment was not completed. A progress note, dated 3/19/25 at 3:07 AM, indicated staff smelled a strong odor of cigarette smoke in R19's room. A police report, dated 3/19/25 at 2:35 PM, indicated the facility called the police to report R19 had been smoking and vaping in R19's room. The responding police officer indicated R19 admitted to vaping in R19's room. A Social Services note, dated 3/19/25 at 1:49 PM, indicated the facility provided R19 with a 30-day discharge notice due to noncompliance with the facility's policies. A progress note, dated 4/1/25 at 12:54 AM, indicated staff responded to R19's room due to a strong odor of cigarette smoke and found a cigarette butt in R19's bathroom. (continued on next page)

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Crossroads Care Center of Weyauwega	717 E Alfred St Weyauwega, WI 54983

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A progress note, dated 4/1/25 at 6:34 AM, indicated staff found several cigarette butts in R19's bathroom, including a butt in R19's bathroom garbage that was still hot and had singed trash. Staff also noted cigarette ashes in R19's toilet. (Surveyor noted R19's bathroom was a shared bathroom between two adjoining resident rooms in which R19 and 3 other residents resided. In addition to R19, the other 3 residents had physical limitations which impaired their ability to evacuate in the event of a fire. One resident had Alzheimer's dementia and a fractured left hip. The other two residents required a Hoyer lift and the assistance of two staff to get out of bed.) A progress note, dated 4/1/25 at 8:02 AM, indicated the facility asked the police department to speak with R19 about staff finding a lit cigarette in R19's garbage. On 4/14/25 at 2:57 PM, Surveyor interviewed Police Officer (PO)-NN who indicated PO-NN had responded to a call to the facility on [DATE]. PO-NN indicated PO-NN interviewed R19 and counseled R19 not to smoke inside of the facility. On 4/7/25 at 12:11 PM, Surveyor interviewed R19 who indicated staff accused R19 of smoking in R19's room. R19 indicated the facility tried to make R19 a supervised smoker but that that did not last. R19 indicated staff tried to take R19's cigarettes away but R19 refused. During the interview, Surveyor noted R19 had a lighter on a lanyard and a pack of cigarettes. On 4/8/25 at 2:23 PM, Surveyor interviewed Social Services Director (SSD)-D who alleged R19 had previously caused a fire in an assisted living apartment due to unsafe smoking practices. On 4/9/25 at 10:52 AM, Surveyor interviewed R19 who confirmed there was a fire at an assisted living facility where R19 resided prior to admission to the facility. R19 indicated the fire started accidentally when R19 disposed of a lit cigarette butt in a plastic cigarette receptacle. R19 indicated someone had put paper in the cigarette receptacle and a fire started when R19 disposed of the cigarette butt. R19 alleged the fire melted the plastic container and damaged the exterior of the facility. R19 indicated the assisted living facility accused R19 of intentionally starting the fire due to an eviction notice. R19 alleged R19 was evicted from the facility due to the incident. On 4/10/25 at 9:08 AM, Surveyor interviewed SSD-D who indicated R19 was given a 30-day notice of discharge on 3/18/25 due to disruptive behavior such as smoking in R19's room and inappropriate sexual behavior. Example 2 - Elopement: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's Elopement Prevention and Missing Resident Policy, dated 12/20/24, indicates: .Elopement is defined as a situation where a resident with cognitive impairment who cannot recognize normal danger and hazard outside the facility leaves the facility without staff knowledge .Upon admission or re-admission, all residents will be assessed for elopement risk utilizing the Elopement Risk Assessment form. A comprehensive elopement prevention plan of care will be developed for each resident identified as at risk for elopement .Residents who are at risk for elopement shall be provided at least one of the following safety precautions: 1. A WanderGuard device that will notify facility staff when the resident has left the building without supervision; 2. Door alarms on facility exits; 3. Staff supervision, either by visual contact or closed-circuit television of facility exits. All WanderGuards, safety devices, and door alarms shall be placed appropriately and maintained .Quality assurance for the prevention of missing residents and allotment: Should a resident attempt to elope, a review of the resident's care plan shall be conducted for possible adjustments and care practices or safety precautions period . From 4/7/25 to 4/10/25, Surveyor reviewed R27's medical record. R27 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, hallucinations, and malnutrition. R27's MDS assessment, dated 2/25/25, indicated R27 had moderate cognitive impairment, unclear speech, and required partial assistance with ambulation. The MDS assessment also indicated R27 was capable of independently wheeling a manual wheelchair at least 150 feet. R27's care plan, initiated 5/9/24 and revised 4/6/25, indicated R27 is at risk for elopement and has a history of attempts to leave the facility unattended. R27 will look to go outside to go fishing. The care plan contained a goal that R27 will not leave the facility unattended and contained the following interventions: Apply WanderGuard. Monitor function and placement; Assess for fall risk; Monitor exit seeking behavior; Monitor for fatigue and weight loss (all initiated 5/9/24); Secure window to only allow partial opening (initiated 10/24/24) Behavior symptom monitoring for R27 indicated R27 had wandering behavior on six days in March 2025 and no wandering behavior in April 2025. No exit-seeking behaviors were documented for March and April 2025. R27's March 2025 Treatment Administration Record (TAR) indicated staff documented R27's WanderGuard was in place every shift except one. On R27's April 2025 TAR, staff did not document WanderGuard placement for the 4/1/25 night (NOC) shift and the 4/8/25 PM shift. A progress note, dated 12/30/24 at 5:37 PM, indicated R27 was redirected back into the facility after exiting out the front door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/9/25 at 1:27 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-V who recalled the incident where R27 exited the building on 12/30/24. LPN-V indicated R27 frequently wanders the building and had increased restlessness, wandering, and exit seeking on 12/30/24. R27 repeatedly said R27 needed to attend a funeral and staff repeatedly directed R27 away from the doors to prevent R27 from leaving the building. LPN-V indicated the WanderGuard system alarmed. LPN-V observed R27 outside the facility but did not witness R27 leave the facility. LPN-V discovered R27 walking on a sidewalk toward the parking lot unsupervised. R27 told LPN-V that R27 had to get to a car to go to a funeral. LPN-V did not recall the time the incident occurred but indicated it was dark when R27 was redirected back into the building. LPN-V did not recall what R27 was wearing at the time. (Surveyor noted the National Weather Service documented the average temperature on 12/30/24 was 38 degrees Fahrenheit and sunset was approximately 4:26 PM.) On 4/8/25 at 3:08 PM, Surveyor observed R27 pace and wander by the central nurses' station and attempt to exit the facility's front doors. R27 exited through the first set of doors, however, staff redirected R27 back into the facility before R27 exited through the second set of doors. The WanderGuard system did not alarm when R27 went through the first set of doors. Surveyor noted R27 was not wearing a WanderGuard. R27 attempted to leave the facility for several more minutes, however, Infection Preventionist (IP)-C repeatedly blocked R27's path to the door. On 4/8/25 at 3:11 PM, Surveyor observed LPN-L ask if R27 was bored. R27 responded affirmatively. LPN-L asked why R27 was trying to go outside. R27 responded, Fishing. Surveyor interviewed LPN-L who confirmed R27 was not wearing a WanderGuard but should have a WanderGuard in place. LPN-L indicated R27 frequently attempts to remove the WanderGuard and has removed the device by chewing, cutting, and pulling at the strap. LPN-L indicated R27 has entered other residents' rooms and the activities room in search of scissors to cut the WanderGuard strap. LPN-L indicated R27 understands the purpose of the WanderGuard and does not want to wear it. LPN-L indicated staff have to check R27's WanderGuard every shift because R27 frequently removes the WanderGuard. LPN-L indicated the facility lost several WanderGuards because R27 removed the WanderGuard and threw it in the trash. On 4/8/25 at 3:12 PM, Surveyor interviewed IP-C who confirmed R27 was not currently wearing a WanderGuard. IP-C indicated IP-C noticed R27 was not wearing a WanderGuard earlier in the shift but had not had a chance to replace the WanderGuard. IP-C confirmed R27 removed WanderGuards on multiple occasions and indicated the facility had lost several WanderGuards due to R27 throwing them away. On 4/8/25 at 3:25 PM, Surveyor observed LPN-C put a WanderGuard on R27's right wrist. R27 immediately tried to remove the WanderGuard with a metal key R27 had found near the nurses' station. On 4/9/25 at 1:12 PM, Surveyor observed a widow directly above R27's bed that opened completely and was large enough for R27 to exit through. (This was contrary to the care plan revision that was made on 10/24/24.) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/9/25 at 1:15 PM, Surveyor interviewed CNA-U who was assigned to R27's unit (the B wing). CNA-U verified R27's window opened all the way and indicated some rooms have screws in the windowsills to prevent the windows from fully opening. CNA-U indicated R27 frequently tests doors in the building and attempts to exit the facility, however, staff usually catch R27 before R27 is able to exit. CNA-U was not aware R27 tries to remove R27's WanderGuard. CNA-U indicated CNA-U and CNA-F were providing care on the A wing approximately two weeks ago when they heard the WanderGuard system alarm. CNA-U and CNA-F finished the care they were providing and responded to the WanderGuard alarm on the B wing. CNA-U and CNA-F found R27 outside the B wing emergency exit door. CNA-U indicated R27 was several feet outside the building and the emergency exit door was closed. CNA-U estimated R27 had been outside for less than five minutes and said R27 was wearing a jacket. CNA-U indicated R27 said R27 was going fishing. CNA-U reported the incident to the nurse. CNA-U did not report the incident to administration and was not asked to write a statement about the incident. (Surveyor noted the Waupaca River was across the road and approximately 800 feet from the facility's entrance.) On 4/9/25 at 2:35 PM, Surveyor interviewed CNA-F who indicated R27 left the building on several occasions. CNA-F verified CNA-U's statement that R27 exited the building through the B wing emergency exit. CNA-F indicated CNA-F and CNA-U were providing care on the A wing approximately two weeks ago when they heard the WanderGuard system alarm. CNA-F responded to the alarm and discovered R27 in a wheelchair a few feet outside the B wing emergency exit. R27 indicated R27 was looking for a good fishing spot. CNA-F informed the nurse R27 had exited the building. CNA-F did not report the incident to administration and was not asked to write a statement about the incident. R27's medical record did not contain documentation in March or April 2025 about R27 exiting the building from the B wing emergency exit door. On 4/9/25 at 1:48 PM, Surveyor interviewed NHA-A who indicated R27 had never eloped. NHA-A confirmed R27 exited the building several times, but did not consider the incidents elopements because R27 was supervised when R27 exited the building. Surveyor requested all elopement investigations and assessments related to R27. On 4/9/25 at 2:20 PM and 3:30 PM, NHA-A indicated the facility did not have any incident reports regarding R27 eloping or exiting the building. NHA-A indicated the facility did not have documentation of investigations, interdisciplinary team (IDT) meetings, or care plan reviews related to R27 exiting the building unsupervised. NHA-A indicated staff are expected to document exit seeking behavior under behavior monitoring and write a progress note about the behavior. The facility's failure to provide supervision to ensure resident safety by failing to ensure R19 did not smoke in R19's room and to ensure that R27 did not or could not exit the facility (by failing to ensure R27's WanderGuard bracelet was in place or that R27's window could not open wide) created a reasonable likelihood for serious harm that led to a finding of immediate jeopardy. The jeopardy was removed on 4/10/25 when the facility implemented the following: 1. Removed smoking materials from R19's room and stored them in a locked area. 2. Reeducated R19 and had R19 sign the facility's smoking policy and behavior contract for smoking. 3. Placed R19 on 15 minute checks to ensure smoking materials are not found in R19's room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Revised R19's care plan to reflect R19's current smoking plan. 5. Updated the facility's smoking policy to include information on where smoking materials will be kept to maintain safety and reduce the risk of unsafe smoking. 6. Educated residents who smoke on the facility's smoking policy, reviewed the designated smoking area, and collected all smoking materials for safe storage. 6. Educated staff on the facility's smoking policy and procedure. 7. Initiated audits to ensure all smoking materials remain locked and the smoking policy is being followed. 8. Placed a WanderGuard on R27 and reviewed R27's order to ensure staff check placement, location, and function daily. 9. Placed R27 on 15 minute checks to monitor R27's location and ensure safety. 10. Secured the window in R27's room. 11. Revised R27's care plan with updated interventions. 12. Reviewed residents at risk for elopement to ensure interventions are appropriate and in place. 13. Educated staff on the facility's elopement policy and the importance of monitoring for exit seeking behavior. 14. Educated staff on the importance of checking for WanderGuard placement and function. 15. Reviewed the facility's elopement policy to ensure information is included regarding what to do when a resident removes a WanderGuard. 16. Initiated audits to ensure WanderGuards are in place and functioning properly.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure physician visits were completed timely for 1 resident (R) (R36) of 5 sampled residents. Regulation allows for a physician to delegate alternating visits to a physician extender, such as a Nurse Practitioner (NP). R36 was not seen by a physician in February 2025 based on an alternating schedule. Findings include: The facility's Physician Services policy, dated 1/1/21, indicates: It is the policy of the facility to provide physician services in accordance with state and federal regulations .12. Residents must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. 13. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. 14. All required physician visits will be made by the physician personally. 15. At the option of the physician, required visits in skilled nursing facilities (SNFs) after the initial visit may alternate between personal visits by the physician and visits by a Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist in accordance with federal and state law . On 4/7/25, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had a diagnosis of congestive heart failure (CHF). R36's Minimum Data Set (MDS) assessment, dated 1/3/25, stated R36's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R36 was not cognitively impaired. R36 was responsible for R36's healthcare decisions. R36's medical record indicated R36 was seen by a physician on 11/26/24 and 12/27/24. R36 was seen by an NP on 1/24/25, 2/12/25, and 3/3/25. R36's medical record did not indicate R36 was seen by a physician in February 2025. On 4/17/25 at 11:53 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated R36's physician told NHA-A that the physician tried to see R36 two weeks in a row in January 2025 but R36 was not in the facility either time. NHA-A indicated R36 goes to the dialysis clinic three times per week. On 4/17/25 at 12:57 PM, Surveyor interviewed NHA-A who provided Surveyor with a hand-written note that stated, 3/25 working on note _ 1/28 attempted 1/23. NHA-A indicated R36's physician attempted to see R36 on 1/23/25 and 1/28/25. The physician saw R36 on 3/25/25 but was still working on the visit note so NHA-A could not provide Surveyor with physician visit note. NHA-A indicated providers do not document in the provider's electronic medical record system when they attempt to see residents. NHA-A indicated only completed visits are documented.

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F 0725 Level of Harm - Minimal harm or potential for actual harm 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. 48794 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. 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. 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. The facility did not ensure sufficient staffing levels were maintained to meet residents' needs in accordance with the Facility Assessment and resident acuity. Findings include: 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. 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. 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. 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49010 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. 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. 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. 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. 50467 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. 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: ~ Licensed staff: 3 on the AM shift; 2 to 3 on the PM shift; 1 on the NOC shift ~ CNAs: 4 to 6 on the AM and PM shifts; 2 to 3 on the NOC shift 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: ~ 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. 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51043 Based on observation, staff interview, and record review, the facility did not provide pharmaceutical services to meet the needs of 3 residents (R) (R300, R24 and R29) of 5 sampled residents. On 4/7/25, Surveyor observed a bottle of 60 milligram (mg) melatonin gummies on R300's bedside table. R300 did not have a physician order to keep medication at the bedside and did not have a self-administration of medication assessment that indicated R300 could self-administer medication. In addition, R300 did not receive bedtime (HS) medications on 4/3/25. On 4/7/25, Surveyor observed a bottle of bovine collagen pills, a bottle of liquid Imodium, and two albuterol inhalers on a table in R24's room. R24 did not have a physician order to keep Imodium at the bedside or a self-administration of medication assessment that indicated R24 could self-administer Imodium. On 4/7/25, Surveyor observed a plastic bag on R29's bed that contained triamcinolone cream and lidocaine ointment. Surveyor also observed a bottle of Elderberry immune health pills in R29's bedside table drawer. R29 did not have a physician order to keep the medications at the bedside or a self-administration of medication assessment that indicated R29 could self-administer all of the medications. Findings include: The facility's undated Self-Administration of Medications Preparation and General Guidelines policy indicates: .A. If the resident desires to self-administer medication, an assessment is conducted by the Interdisciplinary Team (IDT) of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process .C.The IDT verifies the resident's ability to self-administer medication by means of a skill assessment .D. The results of the IDT assessment and of the determination regarding beside storage are recorded in the resident's medical record, on the care plan .E. If the resident demonstrates the ability to safely self-administer medication, a further assessment of the safety of bedside medication storage is conducted .G.The nurse then records such self-administration on the Medication Administration Record (MAR) . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Medication Administration-General Guidelines policy, indicates: .Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration) .4. Five Rights: Right resident, right drug, right dose, right route, and right time are applied for each medication being administered. A triple check of the five rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and .(3) just after the dose is prepared and the medication put away .5. The Medication Administration Record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If the label and the MAR are different .or if there is any reason to question the dosage or directions, the physician's orders are checked for the current dosage schedule .Administration: .2. Medications are administered in accordance with written orders of the prescriber. 3. If a dose seems excessive considering the resident's age and condition, or the medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the pharmacy for clarification prior to administration of the medication or if necessary, contacts the prescriber for clarification . 1. On 4/7/25, Surveyor reviewed R300's medical record. R300 was admitted to the facility on [DATE] and had diagnoses including bacteremia, osteomyelitis of the left ankle and foot, gangrene, diabetes, epilepsy, amputation of left toes, and right below-the-knee amputation. R300's Minimum Data Set (MDS) assessment, dated 4/3/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R300 had intact cognition. R300 made R300's own medical decisions. On 4/7/25 at 1:25 PM, Surveyor observed a bottle of 60 mg melatonin gummies on R300's bedside table. R300 indicated a nurse gave the melatonin to R300 the night before. R300 did not take the melatonin and told the nurse R300 had already taken R300's own melatonin. Surveyor reviewed R300's April 2025 MAR which contained check marks for administered medications. All medications were indicated as administered (including melatonin) every day on each shift as ordered in April except on 4/3/25. On 4/3/25, R300's MAR indicated the following HS medications (all started on 3/28/25) were not administered: Insulin glargine 10 units via subcutaneous injection at HS for diabetes, melatonin 5 mg at HS for insomnia, gabapentin 100 mg at HS for epilepsy, and 10 milliliters (ml) normal saline flush for a peripherally inserted central catheter (PICC) line during the evening shift to ensure patency. A progress note written by Director of Nursing (DON)-B on 4/7/25 indicated R300 had switched rooms. Due to confusion during the move, staff were not sure who was responsible for R300 which resulted in the omission of R300's HS medication. R300's medical record did not indicate the physician was notified that R300's HS medications were not administered. R300's medical record did not contain a self-administration of medication assessment and R300's care plan did not indicate R300 could self-administer medication or keep medication at the bedside. On 4/8/25 at 11:50 AM, Surveyor interviewed R300 who indicated R300 had taken 5 of the 60 mg melatonin gummies that were on R300's bedside table last night and indicated staff did not administer melatonin last night. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 1:07 PM, Surveyor interviewed DON-B who was not sure if the physician was updated regarding the omission of R300's HS medications on 4/3/25. DON-B indicated DON-B updated the physician on 4/7/25 when DON-B became aware the medications were not administered. DON-B indicated the nurse who was responsible for R300 should have notified the physician that R300's medications were not administered as soon as the nurse was aware. DON-B indicated DON-B provided education to nursing staff on 4/2/25 about physician notification and documentation. DON-B indicated a physician's order is needed for medication to be kept at the bedside. DON-B was not aware that R300 had medication at the bedside. 50467 2. On 4/7/25, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had diagnoses including chronic pulmonary edema, pleural effusion, pneumonia, type 2 diabetes, asthma, methicillin-resistant Staphylococcus aureus (MRSA) infection, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and diabetic foot ulcer. R24's MDS assessment, dated 3/16/25, had a BIMS score of 15 out of 15 which indicated R24 had intact cognition. A self-medication care plan, dated 11/11/24, indicated R24 had a physician order for unsupervised self-administration of the following medications: rescue inhaler to be kept at bedside and able to keep Juven collagen and Ensure in room. The care plan contained interventions to assess R24's ability to safely self-administer medication specified on admission/re-admission, quarterly, with changes in medication orders, and with significant changes in condition and to review the findings from the assessment and obtain an order for R24 to self-administer (both interventions dated 9/11/24). A self-administration of medication assessment, dated 9/12/24, indicated the Interdisciplinary Team (IDT) recommended independent self-administration of the following medications .1. Albuterol sulfate HFA inhalation aerosol solution 108 (90 base) micrograms (mcg)/actuation (act) one puff inhale orally every 4 hours as needed. No was marked for additional medications. A self-administration of medication assessment, dated 4/7/25, indicated the IDT recommended independent self-administration of the following medications .1. Juven oral packet every morning and at bedtime. 2. Bovine collagen . supplement, keeps bottle bedside, takes 2 capsules to equal 1000 mg for bone/joint health. 3. Ensure oral liquid 237 ml as needed. No was marked for additional medications. The self-administration of medication assessments did not indicate R24 could self-administer Imodium or keep it at the bedside. 3. On 4/7/25, Surveyor reviewed R29's medical record. R29 was admitted to the facility on [DATE] and had diagnoses including urinary tract infection (UTI), chronic pain syndrome, displaced fracture of lateral condyle of left femur, heart failure, obstructive and reflux uropathy, and anxiety disorder. R29's MDS assessment, dated 2/28/25, had a BIMS score of 14 out of 15 which indicated R29 had intact cognition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care self-medication care plan, dated 4/16/24 and revised 3/17/25, indicated R29 had a physician's order for self-administration of medication for the following medications: Prepared by Registered Nurse/Licensed Practical Nurse/Medication Tech (RN/LPN/MT) and contained interventions to assess R29's ability to safely self-administer medication specified on admission/re-admission, quarterly, with changes in medication orders, and with significant changes in condition and to review the findings from assessment and obtain order for resident to self-administer (both interventions dated 4/16/24). A self-administration of medication assessment, dated 2/9/24, indicated the IDT recommended supervised self-administration of the following medications .1. Bedside with resident. 1b. Comments: [NAME] cartilage. Kept at bedside and supplied by resident. 1c. No additional medications. A monthly compliance visit note, dated 3/28/25 at 10:00 AM and written by the facility's Nurse Practitioner (NP), indicated R29 wanted to have triamcinolone cream at the bedside. The note indicated R29 had triamcinolone cream scheduled twice daily and R29 should not use it more often than that. R29 expressed frustration. On 4/8/24 at 10:22 AM, Surveyor interviewed DON-B who confirmed residents who self-administer medication should have quarterly assessments completed per the facility's policy. DON-B also indicated residents should not have medications at the bedside if they do not have an order for them. On 4/8/25 at 10:45 AM, DON-B indicated unapproved medications from R24 and R29's rooms were removed and education with staff was completed.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on resident and staff interview and record review, the facility did not ensure 3 residents (R) (R203, R24, and R300) of 3 residents reviewed for intravenous (IV) medication were free of significant medication errors. R203 was admitted to the facility on [DATE] with an order for IV antibiotics twice daily after a 42 day admission to the hospital for multiple infections and septic shock. Staff did not initially recognize a dosing error in R203's hospital discharge order for cefepime and entered the order incorrectly. On [DATE], Registered Nurse (RN)-P changed the order without consulting with a physician. Staff did not follow the IV medication order by the discharge physician or the facility's admitting physician. In addition, staff did not administer the IV antibiotic three times in four days. The facility's failure to clarify an IV antibiotic order with the physician, change the order without physician approval, and not administer all doses of the antibiotic led to a finding of immediate jeopardy that began on [DATE]. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on [DATE] at 1:15 PM. The jeopardy was removed on [DATE], however, the deficient practice continues at a scope/severity level D (potential for no more than minimal harm/isolated) as evidenced by the following examples: R24 was not administered a dose of IV antibiotics on [DATE]. R24's physician was not notified that medication was not administered. R300 was not administered a dose of IV antibiotics on [DATE]. R300's physician was not notified that medication was not administered. Findings include: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's undated Medication Administration-General Guidelines policy indicates: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration) .4. Five Rights: Right resident, right drug, right dose, right route and right time are applied for each medication being administered. A triple check of the five rights is recommended at three steps in the process of preparation of a medication for administration: (1) When the medication is selected, (2) When the dose is removed from the container, and finally (3) Just after the dose is prepared and the medication put away .5. The Medication Administration Record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If the label and the MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the current dosage schedule .Administration: .2. Medications are administered in accordance with written orders of the prescriber. 3. If a dose seems excessive considering the resident's age and condition, or medication order seems to be unrelated to the resident's current diagnosis or conditions, the nurse calls the provider pharmacy for clarification prior to administration of the medication or if necessary contacts the prescriber for clarification .This interaction with the pharmacy and/or prescriber and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate . Findings include: 1. From [DATE] to [DATE], Surveyor reviewed R203's medical record. R203 was admitted to the facility on [DATE] and had diagnoses on admission including osteomyelitis of foot, bacteremia due to group B Streptococcus, acute kidney injury, and bilateral cellulitis of lower leg. R203's Admission Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R203 was not cognitively impaired. R203 was responsible for R203's medical decisions. Documentation in R203's medical record indicated the following timeline: ~ From ,d+[DATE]//25 to [DATE], R203 was hospitalized for osteomyelitis. R203 was administered IV antibiotics in the hospital to facilitate healing. ~ On [DATE], R203's hospital discharge paperwork contained an order from Hospital Discharge Physician (HDP)-S for IV cefepime 200 milligrams (mg)/milliliter (ml) injection (commonly known as Maxipime). Inject 20 ml into the vein every 12 hours for 6 days. ~ R203 was admitted to the facility on [DATE]. Facility Physician (FP)-R prescribed cefepime HCl intravenous solution 2 grams (gm)/100 ml. Use 20 ml intravenously two times/day related to osteomyelitis until [DATE]. (Surveyor noted the order from FP-R was different than the discharge order from HDP-S which was cefepime 200 mg/ml, 20 ml every 12 hours at 8:00 AM and 8:00 PM. Since there are 1000 milligrams in a gram, FP-R's order was ,d+[DATE]th of the dose of HDP-S' order.) Staff did not clarify the discrepancy in orders. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ The initial IV cefepime order prescribed by FP-R was listed on R203's MAR as cefepime HCl intravenous solution 2 gm/100 ml. Use 20 ml intravenously two times a day (8:00 AM and 8:00 PM) related to osteomyelitis until [DATE] (Start date: [DATE] at 8:00 PM). ~ R203's MAR indicated the 8:00 PM dose of cefepime was not administered on [DATE]. There was no documentation to indicate the physician was notified that R203 did not receive cefepime. ~ R203's 8:00 AM dose of cefepime HCl 2 gm/100 ml, 20 ml was documented as administered on [DATE]. ~ R203's 8:00 PM dose of cefepime HCl 2 gm/100 ml, 20 ml was documented as administered on [DATE]. ~ On [DATE] at 11:01 PM, R203's cefepime HCl 2 gm/100 ml, 20 ml intravenously twice daily dose order was discontinued by Registered Nurse (RN)-P. ~ On [DATE], a new order was created by RN-P for cefepime HCl intravenous solution 2 gm/100 ml. Use 1 vial intravenously two times a day (8:00 AM and 8:00 PM) related to osteomyelitis until [DATE]. (Start date: [DATE] at 8:00 PM). (Surveyor noted the revised medication order from RN-P on R203's MAR was different from R203's hospital discharge order and the order from FP-R noted above. Surveyor also noted the start time of the order entred by RN-P was 8:00 PM on [DATE] which omitted a dose for R203 on [DATE] at 8:00 AM.) R203's medical record did not contain communication to or from the physician regarding the medication change. ~ R203's MAR indicated R203's 8:00 AM dose of IV cefepime was not administered on [DATE]. R203's medical record did not indicate the physician was notified that R203 did not receive cefepime. ~ Cefepime HCl 2 gm/100 ml, 1 vial intravenously two times a day was documented as administered at 8:00 PM on [DATE] and 8:00 AM on [DATE]. ~ R203's MAR indicated R203's 8:00 PM dose of IV cefepime was not administered on [DATE]. R203's medical record did not indicate the physician was notified that R203 did not receive cefipime. ~ Cefepime HCl 2 gm/100 ml, 1 vial intravenously two times a day was documented as administered at 8:00 AM and 8:00 PM on [DATE] and at 8:00 AM on [DATE]. ~ R203 had an appointment with Infectious Disease Physician (IDP)-Q on [DATE]. IV cefepime was discontinued and R203 was prescribed an oral antibiotic twice daily for 30 days. On [DATE], Surveyor compared the discharge order from HDP-S, the admission order from FP-R, and the adjusted order from RN-P and noted the following: ~ Order 1- Prescribed by HDP-S on [DATE]: cefepime 200 mg per ml. Give 20 ml twice daily. With a concentration of 200 mg per ml, this would be 4000 mg per dose resulting in a daily dose of 8000 milligrams per day. ~ Order 2 - Prescribed by FP-R on [DATE]: cefepime HCl 2 grams (gm) per 100 ml. Give 20 ml twice daily. There are 1000 mgs in a gram, so the dosing is equal to 2000 mg/100 ml. With a concentration of 20 mg/ml this would be 400 mg per dose resulting in a daily dose of 800 mg per day. This dose is 10% of the dose prescribed by HDP-S. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ Order 3 - Not prescribed by a physician and amended autonomously by RN-P on [DATE]: cefepime HCl 2 gms per 100 ml. Give one vial intravenously twice daily. One vial is 2 gms of powder which is reconstituted in 100 ml of saline solution. Two gms is 2000 mg/100 ml for each dose resulting in a daily dose of 4000 mg per day. This dose is 50% of the dose prescribed by HDP-S and 500% (or five times) the dose prescribed by FP-R. On [DATE] at 3:32 PM, Surveyor interviewed RN-P who indicated RN-P was familiar with R203's IV medication orders. RN-P indicated RN-P changed R203's cefepime order on [DATE] because RN-P felt the order did not read right. RN-P stated the order sounded like staff should draw up 20 ml and inject it or insert it into something. RN-P stated RN-P had never seen an order like that before and changed it so it was easier to read. When asked if RN-P consulted with the physician before changing the order, RN-P indicated RN-P looked at the discharge paperwork. RN-P confirmed RN-P did not contact the physician or the pharmacy before changing R203's cefepime order. RN-P indicated RN-P did not notify anyone of the change because RN-P had just corrected the wording. RN-P indicated RN-P made an error when restarting R203's cefepime on [DATE]. RN-P indicated RN-P thought the order would start again at 8:00 AM on [DATE] but was made aware by R203 on [DATE] that R203 did not receive the 8:00 AM cefepime dose which was started at 8:00 PM on [DATE]. Surveyor and RN-P reviewed R203's cefepime in the medication cart. The label on the medication bag and medication read: Cefepime 2 gm in 100 ml 0.9 NS (normal saline). Infuse 100 ml (2 gm) over 30 minutes intravenously twice daily for osteomyelitis (rate 200 ml/hr). RN-P indicated the order on R203's hospital discharge paperwork, the initial order, the order RN-P changed, and the medication labels did not match and were confusing. Surveyor noted the medication packaging was 2 gms of powder in a vial with an attached bag of 100 ml of saline. The powder was to be reconstituted in the saline solution before administering the medication intravenously. On [DATE] at 4:53 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated if a medication is not initialed as administered on the MAR it means the medication was not given. DON-B indicated medications should be administered as ordered or documented why they are not. DON-B indicated the resident's physician should be notified if a medication is not administered and the notification should be documented in the resident's medical record. DON-B indicated medication orders transcribed by RNs must be written by a physician and a second RN should double check the order. DON-B indicated RNs should clarify with the physician and the pharmacy if an order contains an error or is unclear. DON-B indicated staff are not allowed to make changes to a physician order without the physician's knowledge or input. On [DATE] at 11:05 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated discharge orders are signed by the discharging physician. NHA-A indicated when a resident is admitted to the facility, the orders transfer to the resident's medical record and there is no way for FP-R to sign them electronically or otherwise. NHA-A indicated RN-P should have clarified the orders with a physician before making any changes. On [DATE] at 1:40 PM, NHA-A indicated NHA-A did not have documentation to provide to Surveyor that indicated R203's physician was notified that R203 missed three doses of IV cefepime between [DATE] and [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:37 PM, Surveyor interviewed FP-R who indicated the discharge physician's orders are automatically placed under FP-R when a resident is admitted to the facility. FP-R was not aware of a discrepancy and stated the orders should have been transferred over as written by HDP-S. FP-R indicated FP-R had not seen R203 or reviewed R203's chart. FP-R indicated an RN should not alter a physician order without consulting the physician. FP-R indicated orders should be followed exactly as written and if an RN has an issue, the RN should contact FP-R or the discharge physician for clarification. FP-R indicated it is concerning that an order was changed by a nurse without consultation. FP-R indicated it was also concerning that a resident on IV antibiotics with significant infections had missed three doses of IV medication in four days. FP-R indicated staff should notify FP-R when a resident does not receive their medication. FP-R checked notifications for R203 while on the phone with Surveyor and indicated there was no communication regarding R203's missed antibiotic doses. On [DATE] at 8:29 AM, Surveyor interviewed HDP-S who indicated there was an error in the discharge cefepime medication order as it was listed in R203's hospital discharge paperwork. HDP-S indicated staff should have clarified the order with FP-R, IDP-Q, or HDP-S and should not have administered the medication as written. HDP-S indicated the order should have been written as 2 grams. HDP-S indicated it could be concerning for a resident to miss three doses of IV cefepime and stated the facility should have notified the current provider, IDP-Q, or HDP-S. On [DATE] at 12:37 PM, Surveyor interviewed NHA-A who indicated staff are trained on the facility's policies and procedures. NHA-A indicated a nurse cannot make changes to an order without consulting with a physician. NHA-A indicated s nurse should clarify an order if the order is unclear or if the nurse has questions. NHA-A indicated medication orders should be followed as written. On [DATE] at 12:44 PM, Surveyor interviewed DON-B who indicated DON-B had spoken to staff who administered R203's IV cefepime on [DATE] and indicated the full vial was administered for both doses, not the order as it was written at that time. DON-B indicated staff are trained on the facility's policies and should be aware of the expectations. DON-B indicated a nurse cannot change an order without consulting a physician. DON-B indicated RN-P does not work at the facility any longer. On [DATE] at 1:17 PM, Surveyor interviewed R203 who indicated R203 was administered the full dose of cefipime each time R203 received cefepime. R203 indicated R203 was still upset that R203 missed 3 doses of cefepime because R203 had almost died recently. R203 was upset staff did not administer the medication to R203 and was told staff did not have anything for R203 when R203 asked about a missed dose. R203 stated R203 was on the medication for a reason and the facility did not care. The facility's failure to question the discrepancies in R203's medication orders, staff changing the order without consulting a physician, and the facility's failure to ensure all scheduled doses of the ordered antibiotic were given created a reasonable likelihood for serious harm from a significant medication error. The jeopardy was removed on [DATE] when the facility began implementing the following: 1. Reviewed R203's medication orders for accuracy and availability and notified Infectious Disease (ID) of the missed doses. 2. Completed an audit of all residents on antibiotics and verified their medications are available and being administered. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Educated nursing staff on the facility's policy for administering medication per physician orders and what to do when medications are unavailable. 4. Educated nursing staff on confirming pharmacy orders with the physician and that nurses may not change medication orders without physician approval. 5. Initiated audits to ensure admission orders are transcribed correctly and have been received from the pharmacy. The deficient practice continues at a scope/severity level D (potential for no more than minimal harm/isolated) as evidenced by the following: 50467 2. From [DATE] to [DATE], Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had diagnoses including chronic pulmonary edema, pleural effusion, pneumonia, type 2 diabetes, asthma, morbid obesity, methicillin-resistant Staphylococcus aureus (MRSA) infection, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and diabetic foot ulcer. R24's MDS assessment, dated [DATE], had a BIMS score of 15 out of 15 which indicated R24 was not cognitively impaired. R24 had a physician order for vancomycin HCL intravenous solution 1250 mg/250 ml at 12:00 PM for cellulitis. R24's medical record indicated R24 received vancomycin intravenously from [DATE] to [DATE]. R24's MAR indicated the following: ~ R24 received vancomycin at 12:03 PM on [DATE] in the right arm ~ R24 received vancomycin at 11:28 AM on [DATE] in the right arm ~ R24 received vancomycin at 11:59 AM on [DATE] in the left arm ~ R24 received vancomycin at 12:30 PM on [DATE] in the right arm ~ R24 received vancomycin at 11:26 AM on [DATE] in the right arm ~ R24 received vancomycin at 11:09 AM on [DATE] in the right arm ~ R24 received vancomycin at 11:13 AM on [DATE] in the right arm ~ R24 received vancomycin at 2:22 PM on [DATE] in the right arm ~ R24 received vancomycin at 8:43 PM on [DATE] in the right arm ~ R24 received vancomycin at 8:02 PM on [DATE] in the right arm R24's MAR did not indicate vancomycin was administered on [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing note, dated [DATE] at 2:14 PM, indicated R24's Infectious Disease (ID) office was notified that vancomycin would be administered on the PM shift for the next 3 shifts. The ID office confirmed the change. On [DATE], the time for R24's vancomycin administration was changed on R24's MAR from 12:00 PM to 8:00 PM. The medication was not documented as administered on [DATE] and there was no documentation to indicate R24's ID office was updated on the missed dose. On [DATE] at 4:53 PM, Surveyor interviewed DON-B who indicated if a medication is not documented as administered on a resident's MAR, it means the medication was not administered. DON-B indicated medications should be administered as ordered or documented as to why they were not. DON-B indicated a resident's physician should be notified if a medication is not administered and the notification should be documented in the resident's medical record. 51043 3. From [DATE] to [DATE], Surveyor reviewed R300's medical record. R300 was admitted to the facility on [DATE] and had diagnoses including bacteremia, osteomyelitis of left ankle and foot, gangrene, diabetes, epilepsy, amputation of left toes, and right below-the-knee amputation. R300's MDS assessment, dated [DATE], had a BIMS score of 15 out of 15 which indicated R300 was not cognitively impaired. R300 was responsible for R300's medical decisions. On [DATE] at 2:02 PM, Surveyor reviewed R300's [DATE] MAR and noted R300's 10:00 AM 2 gm dose of ceftriaxone (an antibiotic medication) was not administered via R300's peripherally inserted central catheter (PICC) line on [DATE]. Code 2 was documented on R300's MAR which indicated away from home without medications. The order for 2 gm of ceftriaxone administered via PICC line daily was started on admission for osteomyelitis of the foot. R300's medical record did not indicate the physician was notified that R300 did not receive ceftriaxone. On [DATE] at 11:50 AM, Surveyor interviewed R300 who indicated R300 had a physician appointment on [DATE]. On [DATE] at 1:07 PM, Surveyor interviewed DON-B who indicated DON-B could not find any documentation to indicate R300's physician was notified that R300's dose of ceftriaxone was not administered on [DATE]. DON-B indicated R300's physician should have been updated when ceftriaxone was not administered. NHA-A verified R300 left the faciity on [DATE] at 8:30 AM and returned to the facility at 12:03 PM. On [DATE] at 2:35 PM, Surveyor interviewed Facility Physician (FP)-R who was not aware R300 did not receive a dose of ceftriaxone on [DATE]. FP-R indicated FP-R expects staff to notify FP-R if a dose of ceftriaxone is not administered. FP-R indicated if FP-R had been contacted on [DATE], FP-R would have ordered the dose of ceftriaxone to be administered when R300 returned from R300's physician appointment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff interview, and record review, the facility did not ensure drugs and biologicals were stored in accordance with the facility's policy in 1 of 1 medication storage room and 2 of 3 medication carts. In addition, unsecured narcotic medication was stored at the nursing station. This practice had the potential to affect more than 4 of the 49 residents residing in the facility. Medication carts on the B wing and near the nurses' station were left unlocked and unattended. In addition, seven medication cards, including schedule two narcotic medications, were observed in an unlocked desk drawer at the nurses' station. The E wing medication cart contained improperly labeled, undated, and/or expired medications. The D wing medication storage room contained expired medication and medical supplies and unlabeled medication. Findings include: The facility's Equipment and Supplies for Administering Medications policy, revised 1/2018, indicates: .A. The following equipment and supplies are acquired and maintained by the facility for the proper storage, preparation, and administration of medications: 1. Lockable medication carts, cabinets, drawers, and/or rooms . The facility's Medication Administration General Guidelines, revised 1/2023, indicates: .16. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained always for all resident information . The facility's undated Expire dates and Storage policy, indicates: Most insulins should have an expiration date of 28 days after date of opening .Practice Os and Xs, O=open date, X=expiration date .Nurses must write on the product the open and expiration dates .Ophthalmic/eye solutions: Artificial tears for cleanliness and sterilization purposes are expiration dated and disposed of 3 months after opening .Inhalation medications: Advair Diskus - expires 30 days after removal from foil pouch. 1. On 4/8/25 at 4:47 and 4:55 AM, Surveyor observed an unlocked and unattended medication cart at the nurses' station (which was in a common area for residents). On 4/8/25 at 4:57 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-AA who confirmed medication carts should be locked when not attended (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/8/25 at 5:15 PM, Surveyor observed an unattended and unlocked medication cart in the B wing hallway. Surveyor noted the second drawer of the cart was slightly open and an open computer screen on top of the cart contained resident information, including name, medications, room number, and diagnoses. The medication drawers and computer screen faced the hallway. Surveyor observed other people in and at the end of the hallway but did not observe staff in the vicinity of the cart. At 5:17 PM, Surveyor observed Registered Nurse (RN)-P exit a resident's room and walk to the medication cart. On 4/8/24 at 5:17 PM, Surveyor interviewed RN-P who indicated RN-P had just administered medication to a resident. RN-P confirmed RN-P left the medication cart unlocked and unattended and left resident information on a computer screen visible to others. RN-P verified the second drawer of the medication cart was slightly open. RN-P verified RN-P should not have left the medication cart open, unlocked, and unattended and should not have left resident information visible when RN-P stepped away from the cart. 2. On 4/9/25 at 6:12 AM, Surveyor observed RN-X start a narcotic medication count at the end of RN-X's shift. RN-X asked another staff to hang on and removed several rubber banded medication cards from an unlocked drawer at the nurses' station. Surveyor noted the cards contained medications prescribed to residents including 3 cards of pregabalin (an anticonvulsant medication), 1 card of zolpidem (a sedative medication), 1 card of hydrocodone/acetaminophen (a narcotic medication), and 2 cards of oxycodone (an opioid medication). On 4/9/25 at 6:12 AM, Surveyor interviewed RN-X who indicated the medications RN-X removed from the drawer were delivered from the pharmacy around midnight. RN-X confirmed the drawer was unlocked and the medications should have been stored in a locked area. RN-X confirmed there was a locked medication cart on the other side of the nurses' station and a locked medication room in close proximity to the nurses' station. RN-X indicated RN-X was busy and forgot about the medications. RN-X indicated the proper procedure is to keep medications locked until they can be counted at shift change with a second nurse. On 4/10/25 at 12:37 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated medication carts should be locked when not in direct eyesight of the nurse. NHA-A indicated it is not acceptable for staff to leave residents' personal information on a computer screen facing the hallway when they leave the medication cart. NHA-A indicated medications should be stored in a locked area and staff should follow the facility's medication administration protocol. On 4/10/25 at 12:44 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated medication carts should be locked when not in use or when staff walk away. DON-B verified staff should not leave residents' personal information on an unattended computer screen facing the hallway. DON-B indicated medications should be stored in a locked area and not at the nurses' station. 50467 3. On 4/10/25 at 8:28 AM, Surveyor observed the E wing medication cart and noted the following: ~ An open and undated vial of Novolin N 100 units/5 milliliters (ml) ~ An open and undated bottle of Artificial Tears for R21. The expiration date on the bottle was 3/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ An open and undated Advair Diskus inhaler for R21 that did not contain R21's name ~ An open and undated glargine insulin pen for R300 ~ An open and undated fluticasone propionate nasal spray for R11 ~ A bottle of vitamin C 250 milligrams (mg) with an expiration date of 1/2025 On 4/10/25 at 8:50 AM, Surveyor interviewed LPN-Z who confirmed the above medications were not labeled and/or dated appropriately and/or were expired. 4. On 4/10/25 at 8:56 AM, Surveyor observed the D wing medication storage room and noted the following: ~ 5 intravenous (IV) start kits with transparent dressings (Right Way Medical) with expirations dates of 2/28/25 ~ 3 [NAME] infusion administration sets with expiration dates of 1/20/25 ~ 56 orange swab caps with expiration dates of 1/1/23 ~ 139 pink swab caps with expiration dates of 1/1/25 ~ 18 hemoccult developers with expiration dates of 1/2025 ~ 1 bottle of Promote with fiber interfeeding with an expiration date of 4/1/25 ~ 1 cylinder of Arzol silver nitrate application with an expiration date of 9/2024 ~ 77 2 x 2 foam dressings with expiration dates of 12/28/23 ~ 3 Genadyne white PVA foam large dressings with expiration dates of 1/2/25 ~ 5 boxes of adhesive tape remover pads with expiration dates of 10/11/24 ~ 1 4 x 4 non-border foam dressing with an expiration date of 9/1/23 ~ 1 18 french gastrostomy feeding tube with an expiration date of 1/25/25 ~ 5 QuantiFERON TB gold tubes (1 green, 2 purple, 1 gray, and 1 yellow) with expiration dates of 3/31/24 ~ 3 disposable nasopharyngeal swabs 97-2012 with expiration dates of 6/25/23 ~ 5 specimen collection swabs with expiration dates of 6/27/23 ~ 1 sterile foam tipped applicator with an expiration date of 11/1/24 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ 1 23 gauge x 1 inch safety needle with an expiration date of 2/28/25 ~ 1 home medication container with 5 pills per compartment x 7 days for a total of 35 medications on the counter near the bulk storage. The container did not contain a resident's name or a label/list of medications. On 4/10/25 at 10:00 AM, Infection Preventionist (IP)-C verified the above expiration dates with Surveyor and indicated the expired items should not be in the medication room. IP-C could not confirm who the pill container belonged to or what medications were in the container. On 4/10/25 at 12:58 PM, Surveyor interviewed DON-B who confirmed all eye drops, inhalers, insulin, and nasal sprays should be labeled with the resident's name and open date. DON-B also indicated all expired items should be sent back or disposed of and indicated expired supplies should not be kept after the expiration date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49010 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 49 residents residing in the facility. Kitchen staff did not complete appropriate hand hygiene. Logs for testing the parts per million (PPM) of the sanitizing solution in the sanitizer buckets were not completed. Staff did not appropriately test and maintain dishwasher temperatures. Staff completed unsanitary dishwashing. Findings include: On 4/8/25 at 9:03 AM, Dietary Manager (DM)-FF indicated the facility follows the Food and Drug Administration (FDA) Food Code as their standard of practice. Hand Hygiene: The Centers for Disease Control and Prevention (CDC) About Handwashing information from CDC.gov, dated 2/16/24, indicates: Many diseases and conditions are spread by not washing hands with soap and clean, running water. Hand washing with soap is one of the best ways to stay healthy. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands. Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surfaces to person when you: Touch your eyes, nose, and mouth with unwashed hands; Prepare or eat food and drinks with unwashed hands; Touch surfaces or objects that have germs on them; Blow your nose, cough, or sneeze into hands and then touch other peoples' hands or common objects. You can keep yourself and your loved ones healthy by washing your hands often, especially during key times when you are likely to get and spread germs: Before, during, after preparing food; Before and after eating food . Surveyor requested the kitchen's hand hygiene policy but received the facility's Certified Nursing Assistant (CNA)/Nurse hand hygiene policy on two occasions. From 4/7/25 to 4/10/25, the facility was in an active Norovirus outbreak. Multiple staff and residents tested positive and/or experienced symptoms, including kitchen staff. On 4/8/25 at 8:56 AM, Surveyor observed [NAME] (CK)-HH wash dishes. After handling dirty plates and silverware used by residents, CK-HH dipped CK-HH's hands in a bucket of water in which dirty silverware were soaking. After dipping both hands into the bucket, CK-HH wiped CK-HH's hands with a cloth. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/9/25 at 9:00 AM, Surveyor interviewed CK-HH who indicated CK-HH thought CK-HH's hands in the bucket of water was equal to washing CK-HH's hands. When Surveyor asked about the facility's Norovirus outbreak, CK-HH agreed there could be germs on the silverware and stated CK-HH had not thought of that. CK-HH then walked into the kitchen to retrieve items and returned to the dishwashing area. CK-HH did not complete hand hygiene. On 4/9/25 at 9:08 AM, Surveyor interviewed DM-FF who indicated staff should be aware of and practice good hand hygiene which they were trained on numerous times. DM-FF indicated staff should wash their hands in the hand washing sink, not in a bucket of dirty water. Surveyor informed DM-FF of the hand hygiene breach right away as the facility was in an active Norovirus outbreak and the clean dishes that CK-HH was putting away could be contaminated. DM-FF indicated DM-FF would ensure the dishes were rewashed and hand hygiene was completed. On 4/9/25 at 11:21 AM, Surveyor observed CK-GG wash dishes in the dish room. At 11:28 AM, CK-GG left the dish room and entered the kitchen. CK-GG pulled the covers off food on the steam table and prepared to obtain temperatures and serve the lunch meal. After CK-GG picked up plates, Surveyor asked if CK-GG completed hand hygiene after touching the dirty dishes. CK-GG indicated CK-GG should have cleansed hands after touching dirty dishes, but forgot. CK-GG then washed hands in the handwashing sink. Sanitizing Solution: The 2022 FDA Food Code documents at 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness: A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions. The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. The Ecolab Oasis 146 Multi-Quat Sanitizer data sheet indicates the sanitizing solution should be tested for effectiveness by measuring the PPM dilution range. The Hydrion Quat test strips are the appropriate testing strips. The sanitizer solution temperature should be tested and be within 65-75 degrees Fahrenheit. The effective PPM range is 150 to 400 PPM. Surveyor requested a policy on testing the sanitizing solution. An applicable policy was not provided. During an initial kitchen tour that began at 8:17 AM on 4/7/25, Surveyor observed sanitizer buckets and the three-compartment sink. The three-compartment sink contained Oasis 146 Multi Quat Sanitizer which was used to fill the sanitizing section of the sink and the sanitizer buckets. Surveyor requested to see the three-compartment sink and sanitizer bucket testing logs. CK-GG indicated staff test the three-compartment sink sanitizing solution with Hydrion test strips and showed Surveyor the log which included PPM of the sanitizing solution and temperature of the water. CK-GG indicated sanitizer buckets are not tested and do not have a testing log. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/8/25 at 8:43 AM, Surveyor observed Dietary Aide (DA)-II use a rag from the sanitizer bucket. When Surveyor asked DA-II if the PPM for the solution had been tested for effectiveness, DA-II indicated DA-II had not tested the sanitizing solution. DA-II indicated there was no log for testing the sanitizer buckets. On 4/8/25 at 9:39 AM, Surveyor interviewed DM-FF who indicated staff are supposed to test the sanitizer buckets for water temperature and PPM of the sanitizing solution. DM-FF indicated the facility did not have a log for testing the sanitizer buckets. Dishwasher Temperatures: The 2022 FDA Food Code documents at 4-302.13 Temperature Measuring Devices, Manual Warewashing: Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. The effectiveness of cleaners and chemical sanitizers is also determined by the temperature of the water used. A temperature measuring device is essential to monitor manual warewashing and ensure sanitization. Effective mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the warewashing machine meet or exceed the required 71 Celsius (C) (160 Fahrenheit (F)). Parameters such as water temperature, rinse pressure, and time determine whether the appropriate surface temperature is achieved. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical warewashers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 71 C (160 F). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 71 C (160 F). The 2022 FDA Food Code documents at 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures: The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multi-use utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least 160 degrees F as measured by an irreversible registering temperature measuring device to affect sanitization. When the sanitizing rinse temperature exceeds 194 degrees F at the manifold, the water becomes volatile and begins to vaporize reducing its ability to convey sufficient heat to utensil surfaces. The lower temperature limits of 165 degrees F for a stationary rack, single temperature machine, and 180 degrees F for other machines are based on the sanitizing rinse contact time required to achieve the 160 degree F utensil surface temperature. The 2022 FDA Food Code documents at 4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing (B): In hot water mechanical warewashing operations, an irreversible registering temperature indicator shall be provided and readily accessible for measuring the utensil surface temperature. (continued on next page)

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Crossroads Care Center of Weyauwega	717 E Alfred St Weyauwega, WI 54983

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated Cleaning Dishes/Dish Machine policy indicates: All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machine will be checked prior to meals to ensure proper functioning and appropriate temperatures for cleaning and sanitizing .Staff will follow these procedures for washing dishes: 1. Prior to use, verify proper temperatures and machine function .Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitization. Thermal strips may be used as verification that the temperature is adequately hot, but cannot verify the actual temperatures . On 4/8/25 at 8:48 AM, Surveyor observed CK-HH wash dishes. Surveyor and CK-HH observed three dish cycles. The wash temperature for each cycle was appropriate at 166 degrees F, however, the rinse temperature only reached 172 degrees on the first two cycles and 174 degrees on the third cycle. On 4/8/25 at 8:49 AM, DM-FF walked by the dishwashing area and stated, That machine has been off on temps since we got it. On 4/8/25 at 8:50 AM, Surveyor observed CK-HH run a temperature test strip and temperature disk through the dishwasher on a flat rack. The temperature disk measured 171.6 degrees F. CK-HH was unable to find the test strip which was lost in the machine. CK-HH indicated the disk block temperature was not good and should be 180 degrees. At 8:53 AM, CK-HH again ran the temperature disk with a load of dishes. The temperature disk read 167.7 degrees. CK-HH indicated the temperature was lower because the disk was run with dishes. On 4/8/25 at 9:07 AM, Surveyor interviewed DM-FF who indicated the temperature gauge on the dish machine does not work. DM-FF indicated the dishmachine company attempted to fix it in the past and maintenance tried to fix it as well. DM-FF indicated the temperature gauge does not read what it it supposed to read and the temperature disk does not get up to temp, but a paper test strip does. On 4/8/25, Surveyor viewed the dishwashing temperature logs which documented rinse temperatures for every meal with varying temperatures of 180 degrees and above. On 4/8/25 at 9:33 AM, Surveyor interviewed CK-GG who indicated CK-GG runs a temperature test strip every shift but does not keep them. CK-GG indicated the test strips are used to record the temperature on the dishwashing temperature logs. When Surveyor asked how CK-GG is able to get a number for the log when the test strip does not provide a temperature but just turns orange if the temperature is over 180 degrees, CK-GG stated CK-GG did not know, and Surveyor should ask DM-FF. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/8/25 at 9:34 AM, Surveyor interviewed DM-FF who indicated the dishwashing temperature paper strips should be run every meal. DM-FF indicated staff do not keep a log of the test strips. DM-FF indicated the former kitchen manager used to keep the test strips on a calendar due to the ongoing issue with dishwasher temperatures. When Surveyor asked if DM-FF keeps the paper strips since the facility is still experiencing dishwashing temperature issues, DM-FF stated when DM-FF was hired, DM-FF was not instructed to do so. DM-FF indicated there was previous communication with maintenance about a booster to keep the dishwasher temperature levels in compliance, but a booster was not obtained. When asked how temperatures on the log are recorded as 180, 181, 182, and 183 degrees and above when staff indicate the dishwasher does not reach 180 degrees, DM-FF indicated DM-FF was aware that staff falsely write numbers at 180 degrees and above and that the temperature strip does not provide a number to record. DM-FF indicated DM-FF is aware the temperatures on the log are not accurate temperatures. DM-FF verified DM-FF has not addressed the issues and verified the temperature of the dishmachine needs to reach 180 degrees or above to sanitize the dishes. On 4/8/25 at 9:39 AM, Surveyor interviewed DM-FF who indicated DM-FF had proof the dishwashing machine was an ongoing issue. DM-FF indicated the facility has a company that comes monthly to look at the entire kitchen for regulatory compliance. DM-FF indicated DM-FF receives a report of how the facility does each month and the report is presented at the facility's monthly Quality Assurance Performance Improvement (QAPI) meeting. DM-FF provided Surveyor with a copy of the report from 10/22/24. The report indicated the dishwasher rinse temperature needs to reach 180 degrees but only reached a maximum of 170. 9 degrees in three cycles. DM-FF indicated the information was provided at the next QAPI meeting, but no changes had been made. On 4/8/25 at 9:48 AM, Surveyor interviewed CK-HH who indicated CK-HH records temperatures over 180 degrees on the dishwashing log because everyone else does. On 4/8/25 at 9:56 AM, Surveyor interviewed Maintenance Director (MD)-JJ who indicated MD-JJ does not believe the temperature gauge on the dishwasher works, which is an ongoing problem. MD-JJ indicated MD-JJ previously requested a booster but was told a booster cannot be put on the machine. MD-JJ indicated a company checked the machine, and they said the machine is working correctly. MD-JJ indicated MD-JJ did not have any paperwork or a receipt to indicate to the facility the dishmachine was working correctly and reached the appropriate temperature. MD-JJ indicated MD-JJ usually uses the temperatures staff write on the log when MD-JJ checks the dishmachine for compliance. MD-JJ reiterated MD-JJ does not think the temperature gauge works correctly. On 4/8/25 at 10:36 AM, Surveyor observed MD-JJ run a paper test strip through the dishwashing machine. The strip turned orange which indicated a temperature of 180 degrees or above, however, the gauge on the dishmachine read 168 degrees. Surveyor reviewed the results of the facility's previous recertification survey and noted the dishwasher temperature gauge was not working appropriately at that time and the facility relied on paper test strips. Unsanitary Dishwashing Practice: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2022 FDA Food Code documents at 2-301.14 When to Wash. Food Employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles, and: .(E) After handling soiled equipment or utensils; .(H) Before putting on gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands. The facility's undated Cleaning Dishes/Dish Machine policy indicates: .2. The person loading dirty dishes will not handle the clean dishes unless they change into a clean apron and wash hands thoroughly before moving from dirty to clean dishes. On 4/8/25 at 8:56 AM, Surveyor observed CK-HH wash dishes. After handling dirty plates and silverware used by residents, CK-HH did not complete hand hygiene and was not wearing an apron. CK-HH began to put clean dishes away without washing hands. On 4/9/25 at 9:00 AM, Surveyor interviewed CK-HH who did not realize CK-HH could be contaminating clean dishes. Surveyor observed CK-HH continue to put away clean dishes without rewashing them. On 4/8/25 at 9:07 AM, Surveyor interviewed DM-FF who indicated staff should wash their hands before going from dirty dishes to clean dishes. DM-FF indicated staff are well trained on the procedure and should be following it. On 4/10/25 at 12:37 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated kitchen staff should be aware of and follow the facility's policies and procedures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation, staff and resident interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection. This practice had the potential to affect all 49 residents residing in the facility. The facility's gastrointestinal illness (GI) outbreak line lists did not include last symptom dates or times for affected employees and residents. R24 should have remained on contact precautions related to GI illness until after 7:39 AM on 4/8/25. The facility removed R24 from contact precautions on 4/7/25. R44 should have remained on contact precautions related to GI illness until after 10:00 AM on 4/9/25. The facility removed R44 from contact precautions on 4/7/25. R22 was on enhanced barrier precautions (EBP) due to colonization of a multidrug-resistant organism (MDRO). Licensed Practical Nurse (LPN)-E did not wear a gown when LPN-E manipulated R22's clothing to administer a pain patch on 4/7/25. On 4/8/25, residents were not offered hand hygiene before or after breakfast in the main dining room. R23 was on EBP. On 4/8/25, staff did not follow the facility's infection control protocol when handling soiled linen and refuse and while providing high-contact care for R23. R402 was on EBP. On 4/8/25, staff did not ensure a mechanical lift was sanitized after a transfer for R402. R7 was on contact precautions. On 4/9/25, staff entered R7's room without donning personal protective equipment (PPE). Findings include: The facility's Infection Control-Norovirus policy, dated 2/4/21, indicates: The facility's policy ensures appropriate infection prevention and control measure are taken to prevent the spread of infection per state and federal regulations and national guidelines .To help control the spread of infection: 1. Close unit to visitors until symptoms have cleared for 48 hours .11. Use standard and droplet contact precautions with careful attention to hand hygiene .Use a mask when cleaning up diarrhea and vomit. 12. Contact precautions should always be used when caring for incontinent residents, during outbreaks, and when there is the possibility of splashes that might lead to contamination of clothing .When an outbreak is suspected or occurs: .5. Begin a line listing of ill individuals (staff and residents). a. Complete line listing for the duration of the outbreak (until you have no new cases for 48 hours) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An Action Plan attached to the policy indicates to implement contact precautions for all residents suspected or confirmed with acute gastroenteritis (AGE) and continue precautions for a minimum of 48 hours after the resolution of AGE symptoms .Monitor healthcare personnel absenteeism due to diarrhea and/or vomiting symptoms and exclude those with gastroenteritis symptoms from patient care for at least 48 hours after resolution of symptoms .Use soap and water for hand hygiene (instead of antibacterial hand rub) after providing care or having contact with residents with AGE symptoms. The facility's Infection Control-Linen Management policy, dated 2/4/21, indicates: The facility's policy is to ensure lines are handled to prevent cross-contamination and the spread of infection per state and federal regulations and national guidelines. Guidelines: .4. Dirty linens are contained in a closed container or bag. 5. Dirty linens are to be handled in a way to prevent aerosolizing infectious agents. The facility's Infection Control-Cleaning and Disinfection/Non-Critical and Shared Equipment policy, dated 2/4/21, indicates: .5. Any equipment used in rooms must be cleaned with a disinfectant wipe immediately after use/upon exit of the room .C. Mechanical lift equipment. 1. On 4/9/25, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had a diagnosis of congestive heart failure (CHF). R24's Minimum Data Set (MDS) assessment, dated 3/16/25, stated R24's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R24 was not cognitively impaired. R24 was responsible for R24's healthcare decisions. On 4/925, Surveyor reviewed R44's medical record. R44 was admitted to the facility on [DATE] and had a diagnosis of diabetes mellitus. R44's MDS assessment, dated 3/9/25, stated R44's BIMS score was 11 out of 15 which indicated R44 had moderate cognitive impairment. R44 was responsible for R44's healthcare decisions. On 4/7/25 at 10:30 AM, Surveyor observed R24's room door which contained an EBP sign but not a contact precautions sign. On 4/9/25, Surveyor reviewed the facility's Norovirus outbreak documents which included emails to/from Infection Preventionist (IP)-C and a County Health Nurse, dated 4/7/25, that indicated at 10:34 AM, the County Health Nurse informed the facility that 2 of 3 samples from the facility tested positive for Norovirus. At 10:44 AM, IP-C informed the County Health Nurse via email that the facility opened the A wing due to infection is not spreading through the facility anymore. Included in the outbreak documents was a typed timeline that indicated the facility shut down the A wing on 3/31/25 for possible Norovirus due to 4 residents with active GI symptoms and contacted the County Health Department. A timeline indicated the facility opened the A wing on 4/7/25 and received an email from the County Health Nurse confirming 2 of 3 tests sent out were positive for Norovirus. The timeline indicated there were 3 new positive residents in the facility on 4/8/25, 2 on the A wing and 1 on the B wing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the facility's Norovirus outbreak line lists, including 1 list for staff and a separate list for residents. The line lists indicated a staff member was the first person with symptoms on 3/24/25. The staff list included the date of onset, signs/symptoms, and a return to work date for each affected staff. The staff line list did not include the date/time of the last symptom (needed to determine how long to stay off of work as indicated in the facility's policy). The resident line list included the date of onset, signs/symptoms, room numbers, and resolved dates. The resident line list did not include the date/time of last symptom (needed to determine how long to keep the resident on transmission-based precautions as indicated in the facility's policy). On 4/9/25 at 8:52 AM, Surveyor interviewed IP-C who indicated Certified Nursing Assistant (CNA)-N, whose name was on the staff line list with no additional information, had called in on 4/9/25. IP-C was not aware of CNA-N's symptoms yet. On 4/9/25, Surveyor reviewed the resident line list which indicated R24 had an onset date of 4/5/25 with diarrhea. The line list indicated R24's illness was resolved on 4/7/25. Surveyor reviewed R24's medical record which contained CNA documentation that indicated R24's last loose stool was on 4/6/25 at 7:39 AM. The resident line list also indicated R44 had an onset date of 4/4/25 with diarrhea. The line list indicated R44's illness resolved on 4/7/25. Surveyor reviewed R44's medical record which contained a note, dated 4/3/25 at 8:47 AM, that indicated R44 continued to have looser stool than normal into this morning from last night. A note, dated 4/7/25 at 9:30 AM, indicated R44 was removed from contact precautions due to no signs/symptoms of nausea, vomiting, or diarrhea for 48 hours. R44's medical record contained CNA documentation that indicated R44 had watery stools on 4/5/25 and 4/6/25. CNA documentation indicated R44's last loose stool was on 4/7/25 at 10:00 AM. On 4/9/25, Surveyor reviewed the facility's call-in list used by Human Resources (HR). The HR list did not include signs/symptoms, end dates, or return to work dates. Examples included the following: ~ CNA-F had an onset date of 3/25/25 with symptoms of fever, cough, body aches, and congestion. The HR call-in list did not contain symptom resolution or return to work dates. ~ CNA-G had an onset date of 3/26/25 with symptoms of diarrhea and lethargy. The HR call-in list did not contain symptom resolution or return to work dates. ~ CNA-H had an onset date of 3/30/25 with symptoms of congestion and fever. The HR call-in list did not contain symptom resolution or return to work dates. Surveyor reviewed the facility's employee line list which included the following examples: ~ Physical Therapy Assistant (PTA)-K had an onset date of 3/30/25 with symptoms of vomiting, diarrhea, and light headedness. The HR call-in list contained a return to work date of 4/3/25 but no symptom resolution date ~ Certified Occupational Therapy Assistant (COTA)-M had an onset date of 3/30/25 with symptoms of vomiting and diarrhea. The HR call-in list contained a return to work date of 4/2/25 but no symptom resolution date (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In addition, comparison of the facility's outbreak staff line list with the HR call-in list revealed the following: ~ CNA-I had an onset date of 3/24/25 with symptoms of vomiting, fever, and diarrhea. The staff line list contained a return to work date of 3/28/25 but no symptom resolution date. CNA-I was not on the HR call-in list. ~ CNA-J had an onset date of 3/24/25 on the staff line list. The HR call-in list indicated CNA-J had an onset date of 3/25/25. ~ CNA-G had an onset date of 3/24/25 on the staff line list. The HR call-in list indicated CNA-G had an onset date of 3/26/25. ~ LPN-L had an onset date of 4/3/25 with symptoms of fever, chills, vomiting, and diarrhea. The staff line list had a return to work date of 4/7/25 but no symptom resolution date. LPN-L was not on the HR call-in list. On 4/9/25 at 10:55 AM, Surveyor interviewed COTA-M who verified the illness listed on the staff line list and indicated COTA-M's symptoms ended in the early morning hours of 3/31/25. COTA-M could not recall the specific time of COTA-M's last loose stool. COTA-M indicated COTA-M returned to work on 4/2/25 at 7:00 AM. On 4/9/25 at 11:18 AM, Surveyor interviewed IP-C who indicated the GI outbreak was identified on 3/31/25. IP-C indicated IP-C, Nursing Home Administrator (NHA)-A, and HR determined the outbreak status together. IP-C indicated IP-C noticed the first resident with signs/symptoms of GI illness on 3/31/25. IP-C indicated multiple residents then displayed symptoms of illness and the facility closed the A wing because all of the residents who were sick on that date resided on that wing. IP-C indicated IP-C uses a report from the facility's electronic medical record system that shows if a resident had any symptoms (per nursing progress notes) for the previous 72 hours to determine when residents can come off of contact precautions. IP-C indicated employees must update the facility daily on how they are feeling. Either DON-B or HR determines when 48 hours has passed since the employee's last symptom of illness. Following a discussion of the above information for R24's GI illness, IP-C verified R24 should have remained on contact precautions until after 7:30 AM on 4/8/25. IP-C indicated CNA documentation does not pull to the report IP-C uses to determine symptom resolution for the resident line list. IP-C verified there should have been a contact precautions sign on R24's door at the time of the observation noted above. Following a discussion of the above information for R44's GI illness, IP-C verified R44 should have remained on contact precautions until after 10:00 AM on 4/9/25. IP-C indicated IP-C removed R44 from contact precautions too soon. Following a discussion of the above discrepancies and lack of information on the staff line list, IP-C verified the missing information was relevant to monitor the facility's outbreak status. IP-C indicated there were still 3 residents on contact precautions, 2 on the A wing and 1 on the B wing. When asked if the County Health Department was notified of the new cases, IP-C indicated the most recent update to the County Nurse was on 4/7/25 via the emails listed above. IP-C indicated IP-C had not updated the County Health Department on the new cases. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/9/25 at 12:02 PM, Surveyor interviewed IP-C who indicated the difference between the staff line list and the HR call-in list is that the staff line list indicates the date of staffs' first symptom and the HR call-in list indicates the date the employee called in sick. IP-C indicated the employee (CNA-N) that was added to the line list that day (4/9/25)had called in on 4/9/25 for nausea and diarrhea with symptoms that started on 4/7/25. IP-C was unsure of when CNA-N last worked. On 4/9/25 at 12:18 PM, Surveyor interviewed PTA-K via phone. PTA-K verified the illness listed on the staff line list and indicated PTA-K was pretty sure PTA-K's symptoms ended on 4/1/25 when PTA-K had a last loose stool in the morning. PTA-K could not recall the time of PTA-K's last loose stool and indicated PTA-K returned to work on 4/3/25 at 8:30 AM. On 4/9/25 at 12:32 PM, Surveyor reviewed CNA-N's time card report which indicated CNA-N last left work on 4/6/25 at 6:12 AM prior to CNA-N's illness onset on 4/7/25. 2. The facility's Enhanced Barrier Precautions policy, dated 3/25/24, indicates: It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention and transmission of multidrug-resistant organisms (MDROs) .EBP refer to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high-contact resident care activities .4. High-contact care activities include: a. Dressing .Table 1 of the policy indicates a resident who is colonized with a CDC-targeted MDRO should be placed on EBP. On 4/7/25, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including unspecified dementia and history of urinary tract infection with extended-spectrum beta-lactamase (ESBL) bacteria (ESBLs are considered MDROs and contain enzymes which break down certain antibiotics making infections difficult to treat). R22's MDS assessment, dated 4/2/25, stated R22's BIMS score was 4 out of 15 which indicated R22 had severe cognitive impairment. R22 had a Power of Attorney for Healthcare (POAHC) who was responsible for R22's healthcare decisions. On 4/7/25 at 9:29 AM, Surveyor observed LPN-E enter R22's room to apply a lidocaine patch to R22's left lower back. Surveyor observed a sign on R22's door that indicated staff must wear gloves and a gown for high-contact resident care activities such as dressing. Surveyor observed LPN-E lift R22's shirt with gloved hands while R22 leaned slightly forward in R22's wheelchair. LPN-E applied the lidocaine patch to R22's left lower back, removed gloves, and completed hand hygiene. LPN-E then obtained tape from the medication cart, dated the tape with a marker, applied the tape to the lidocaine patch on R22's back, adjusted R22's shirt back, and transported R22 to the activity room. LPN-E did not wear a gown during the observation. On 4/7/25 at 9:31 AM, Surveyor interviewed LPN-E who indicated R22 was on EBP due to a history of MDRO infection. LPN-E indicated staff should wear a gown and gloves when completing invasive care. LPN-E indicated if staff dealt with R22's urine, they needed to gown and glove. On 4/7/25 at 2:18 PM, Surveyor interviewed IP-C who thought staff only needed to gown and glove for R22 when providing cares related to urine. IP-C indicated that was how IP-C was taught by the facility's previous IP and IP-C educated staff the same way. IP-C verified the facility's policy states gown and gloves should be worn for high-contact cares such as dressing. IP-C indicated IP-C educated staff to read the EBP sign on a door prior to entering the room. IP-C verified LPN-E should have worn a gown to apply R22's lidocaine patch because the adjustment of clothing was involved. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	49010 3. The Centers for Disease Control and Prevention (CDC) About Handwashing information from CDC.gov, dated 2/16/24, indicates: Many diseases and conditions are spread by not washing hands with soap and clean, running water. Hand washing with soap is one of the best ways to stay healthy. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands. Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surface to person when you: Touch your eyes nose and mouth with unwashed hands; Prepare or eat food and drinks with unwashed hands; Touch surfaces or objects that have germs on them; Blow your nose, cough, or sneeze into hands and touch other people's hands or common objects. You can keep yourself and your loved ones healthy by washing your hands often, especially during key times when you are likely to get and spread germs: Before, during, after preparing food; Before and after eating food . From 4/7/25 to 4/10/25, the facility was in an active Norovirus outbreak. 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, deliver and prepare food, and assist with condiments, however, CNA-DD did not offer residents hand hygiene before or after the meal. Surveyor noted R23 and R402 required feeding assistance and were seated at different tables. Surveyor observed CNA-DD assist R23 and R402, however, CNA-DD did not offer R23 and R402 hand hygiene before or after assisting them with eating. On 4/8/25 at 8:14 AM, Surveyor interviewed R41 who stated R41 was not offered hand hygiene. On 4/8/25 at 8:26 AM, Surveyor interviewed CNA-DD who indicated CNA-DD had to work alone because no other staff came to the dining room. CNA-DD stated CNA-DD did not offer or assist any of the residents in the dining room with hand hygiene because CNA-DD was the only staff in the dining room. 4. The facility's Infection Control Linen Management policy, dated 2/4/21, indicates: The facility's policy is to ensure linens are handled to prevent cross-contamination and the spread of infection per state and federal regulations and national guidelines .5. Dirty linens are contained in a closed container or bag. 6. Dirty linens are to be handled in a way to prevent aerosolizing infectious agents (i.e., Do not shake linens). Procedure: . 5. Carry linen by holding it away from your body . On 4/9/25 at 5:17 AM, Surveyor observed CNA-Y enter a resident's room on the E wing with an EBP sign at the entrance. CNA-Y donned the appropriate personal protective equipment (PPE) to assist the resident. At 5:39 AM, Surveyor observed CNA-Y exit the room. CNA-Y was not wearing a gown or gloves and was carrying a clear plastic bag of items which CNA-Y held tightly to CNA-Y's chest with both arms. Surveyor observed a brown blanket on top of the plastic bag. The blanket was not in the bag and touched CNA-Y's arms, chest, and under CNA-Y's chin as CNA-Y carried the bag and blanket across the hall to the utility room. Following the observation, Surveyor interviewed CNA-Y who verified CNA-Y carried soiled linens from a resident's room to the utility room and put them into a designated laundry container. When Surveyor asked CNA-Y if the blanket had been on the resident's bed, CNA-Y stated yes but it was an extra blanket so CNA-Y removed it and put it in the dirty laundry to be washed. (continued on next page)

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	525315	A. Building B. Wing	04/17/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/10/25 at 12:44 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B expects staff to be aware of and follow the facility's infection control policies and practices. 50467 5. On 4/8/25 at 5:07 AM, Surveyor observed CNA-CC exit R23's room in a gown and gloves and carry unbagged clothing and linens down the hallway to a soiled linen cart. R23 was on EBP and had an EBP sign on R23's door. CNA-CC disposed of the soiled items and then reached under her CNA-CC's gown with soiled gloves. CNA-CC retrieved a walkie talkie and called for assistance to transfer R23. CNA-CC then put the walkie talkie back under R23's gown, walked down the hallway, and re-entered R23's room wearing the same PPE. On 4/8/25 at 5:11 AM, Surveyor observed CNA-Y assist with a transfer for R23. CNA-Y donned gloves for the transfer but did not don a gown. On 4/8/25 at 5:11 AM, Surveyor entered R23's room to observe CNA-CC and CNA-Y transfer R23. When Surveyor asked if R23 was on EBP, CNA-CC indicated a resident down the hall was sick and that is why a gown and gloves were needed. When Surveyor mentioned the EBP sign on R23's door, CNA-CC looked at the sign and confirmed R23 was on EBP. CNA-CC indicated CNA-CC and CNA-Y should be wearing PPE. On 4/8/25 at 5:23 AM, Surveyor interviewed LPN-AA who confirmed staff should not be in the hallway with unbagged soiled clothing and linens. LPN-A indicated all soiled items should be bagged if they are being carried in the hallway. On 4/8/25 at 5:31 AM, Surveyor observed CNA-CC exit R23's room again with soiled linens while wearing PPE. CNA-CC then walked back and re-entered R23's room. On 4/8/25 at 5:43 AM, Surveyor interviewed CNA-CC who confirmed soiled linens and clothing should be bagged prior to transporting them in the hallway. 6. On 4/8/25 at 7:34 AM, Surveyor observed LPN-T and CNA-QQ transfer R402 via mechanical lift. Following the transfer, LPN-T wheeled the lift into the hallway and walked away. When Surveyor asked LPN-T if the lift should be sanitized, LPN-T stated, I guess, if I can find wipes. LPN-T found wipes and sanitized the lift. 7. On 4/9/25 at 10:52 AM, Surveyor observed CNA-F enter R7's room without donning PPE. R7 was on contact precautions and had a contact precautions sign on R7's door. On 4/9/25 at 1:07 PM, Surveyor observed again CNA-F enter R7's room without donning PPE. When CNA-F exited the room, Surveyor asked if CNA-F should have worn PPE. CNA-F indicated CNA-F just plugged in a cord. When Surveyor asked if R7 was on contact precautions, CNA-F looked at R7's door and confirmed R7 was on contact precautions. CNA-F then confirmed CNA-F should have worn PPE when CNA-F entered the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/10/25 at 12:57 PM, Surveyor interviewed IP-C who confirmed staff should wear PPE during direct cares such as dressing, changing, and transfers. IP-C confirmed soiled linens and clothing should not be transported in the hallway if not bagged or in a linen container. IP-C also confirmed staff should don PPE prior to entering a resident's room and remove PPE prior to exiting a resident's room. IP-C indicated all equipment should be sanitized between use per the facility's policy.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure 2 residents (R) (R27 and R36) of 5 sampled residents were provided influenza or pneumococcal vaccines as indicated. R27's Power of Attorney for Healthcare (POAHC) gave consent for R27 to receive the influenza vaccine. The facility did not administer the vaccine. R36 was eligible for and signed consent to receive a pneumococcal vaccine. The facility did not administer the vaccine. Findings Include: The facility's Influenza, COVID, and Pneumococcal Immunizations for Residents policy, dated 2/4/21, indicates: The facility's policy ensures that the resident receives influenza and pneumococcal immunizations per state and federal regulations and national guidelines .5. Influenza immunization will be offered in accordance with the Centers for Disease Control and Prevention (CDC) .5. Pneumococcal immunization will be offered in accordance with the CDC. 1. On 4/7/25, Surveyor reviewed R27's medical record. R27 was admitted to the facility on [DATE] and had a diagnosis of Parkinson's disease. R27's Minimum Data Set (MDS) assessment, dated 2/25/25, stated R27's Brief Interview for Mental Status (BIMS) score was 9 out of 15 which indicated R27 had moderate cognitive impairment. R27 had an activated POAHC who was responsible for R27's healthcare decisions. On 4/7/25, Surveyor reviewed a Vaccine Administration Record-Immunization Consent Form for R27 with a signature line that indicated verbal consent was received from R27's POAHC on 10/25/24. The form indicated R27's POAHC gave consent for R27 to receive the influenza vaccine but declined all other vaccines offered. R27's medical record did not indicate R27 received the influenza vaccine. On 4/7/25 at 2:10 PM, Surveyor interviewed Infection Preventionist (IP)-C who indicated R27 should have received an influenza vaccine but did not. 2. On 4/7/25, Surveyor reviewed R36's medical record. R36 was admitted to facility on 11/18/24 and had a diagnosis of congestive heart failure (CHF). R36's MDS assessment, dated 1/3/25, stated R36's BIMS score was 15 out of 15 which indicated R36 was not cognitively impaired. R36 was responsible for R36's healthcare decisions. On 4/7/25, Surveyor reviewed an Authorization and Release for Pneumococcal Vaccine signed by R36 and dated 11/29/24. The form indicated R36 consented to receive a pneumococcal vaccine. R36's medical record did not indicate R36 received a pneumococcal vaccine. On 4/7/25 at 2:07 PM, Surveyor interviewed IP-C who indicated R36 should have received a pneumococcal vaccine but did not.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R9) of 5 sampled residents was offered a COVID-19 vaccine as indicated. R9's Power of Attorney for Healthcare (POAHC) gave consent for R9 to receive a COVID-19 vaccine. The facility did not administer the vaccine. Findings include: The facility's Influenza, COVID and Pneumococcal Immunizations for Residents policy, dated 2/4/21, indicates: The facility's policy ensures the resident receives influenza and pneumococcal immunizations per state and federal regulations and national guidelines .5. COVID immunization will be offered in accordance with the Centers for Disease Control and Prevention (CDC) . On 4/7/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had a diagnosis of chronic obstructive pulmonary disease (COPD). R9's Minimum Data Set (MDS) assessment, dated 2/18/25, stated R9's Brief Interview for Mental Status (BIMS) score was 10 out of 15 which indicated R9 had moderate cognitive impairment. R9 had an activated POAHC who was responsible for R9's healthcare decisions. On 4/7/25, Surveyor reviewed an undated Authorization and Release for COVID-19 Vaccine that contained the signature of R9's POAHC and indicated consent for R9 to receive a COVID-19 vaccine. R9's medical record did not indicate a COVID-19 vaccine was administered. On 4/7/25 at 2:14 PM, Surveyor interviewed Infection Preventionist (IP)-C who indicated R9 should have received a COVID-19 vaccine but did not.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 40342 Based on staff interview and record review, the facility did not ensure staff received required Quality Assurance Performance Improvement (QAPI) training. This practice had the potential to affect all 49 residents residing in the facility. The facility did not provide staff with required annual training on the facility's QAPI program. Findings include: The facility's Quality Assurance Performance Improvement (QAPI) Plan/Program, dated 9/27/19, indicates: AAHealthcare pursues the highest quality of care and services for our residents and customers through a data-driven, proactive approach to improving the quality of life, care, and services at our facility while emphasizing autonomy and resident choice. Purpose: Involving all members of the organization to create a pro-active process to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor for effectiveness of interventions .In our organization, QAPI includes all employees, all departments, and all services provided . The Governing Body delegates the responsibility of the QAPI Program to the Administrator. The Administrator has been delegated responsibility for assuring the QAPI Program is in compliance with federal, state, local, and all other regulatory requirements .Leadership responsibilities include: .Ensuring staff time, equipment, and technical training . On 4/17/25, Surveyor reviewed the facility's education for Certified Nursing Assistant (CNA)-F, CNA-LL, CNA-KK, CNA-MM, and CNA-D and noted the education provided did not include QAPI program education. On 4/17/25 at 11:55 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the above CNAs did not receive QAPI program education but should have.