STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525417	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads Care Center of Milwaukee	3216 W Highland Blvd Milwaukee, WI 53208

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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** 12679 Based on record review, staff interview, and facility policy review, the facility failed to ensure hospital physicians orders were implemented for one of one resident (Resident (R) 1) reviewed for implementation of physician orders out of a survey sample of nine. Specifically, the facility failed to obtain a laboratory blood test for vitamin D (to determine low bone density, fatigue, bone pain). In addition, the facility failed to coordinate services with R1's responsible party to ensure that one medical appointment was to be scheduled after the resident was discharged by the hospital and readmitted back to the facility. This failure had the potential for the resident to not receive appropriate continuum of care. (Cross Reference F690 and F692) Findings include: Review of a facility policy titled Physician Orders, dated 01/31/18, indicated .To provide general guidelines when receiving, entering, and confirming physician or prescriber's order. The policy failed to address following physician orders from another medical system when a resident was admitted or readmitted to the facility. Review of R1's electronic medical records (EMR) titled Admission Record, located under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses that included post stroke, anxiety disorder, and vascular dementia. Review of R1's EMR titled admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/24/24, indicated the resident had a Brief Interview of Mental Status (BIMS) score of six out of 15, which revealed the resident was severely cognitively impaired. Review of R1's EMR titled Care Plan, located under the Care Plan tab and dated 05/29/24, indicated the resident had impaired memory with decision-making and had a legal guardian who was the decision-maker for the resident. Review of R1's EMR titled nursing Progress Notes, located under the Prog (Progress) Note tab and dated 08/02/24, indicated the facility received a call from R1's physician's office. The office called the facility to notify them that the resident was being transported to the emergency room due to low blood pressure and dizziness. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's EMR titled hospital Discharge Summary, located under the Misc (Miscellaneous) tab and dated 08/14/24, indicated R1 arrived at the hospital, directly from a medical appointment due to being hypotensive (low blood pressure). The physician who wrote the discharge summary also indicated the resident had an elevated PSA (prostate-specific antigen blood test to identify possible cancer), and a referral was made to a urologist. Finally, the physician indicated the resident had a low vitamin D level and was treated with supplements and recommended a blood level to be drawn on 10/01/24, to determine if the resident required additional supplements to treat his low vitamin D level. Review of R1's EMR titled SNF (Skilled Nursing Facility) progress notes, located under the Prog Note tab and dated 09/17/24, indicated the Nurse Practitioner (NP) mentioned the resident had an outpatient appointment for urology for an elevated PSA. Review of R1's EMR titled SNF progress notes, located under the Prog Note tab and dated 09/19/24, 09/26/24, 10/01/24, and 10/08/24, indicated the NP mentioned on each date that the resident had an outpatient appointment for urology for an elevated PSA. A review was conducted of R1's EMR, and there was no evidence the resident received a physician's order for a blood draw to check his vitamin D level. There was no evidence in the clinical record that the facility had followed up on the hospital referrals for a follow-up urology appointment. During an interview on 10/29/24 at 3:39 PM, Licensed Practical Nurse (LPN)1, who was also the Unit Manager for the third floor, stated she reviewed the records for R1 and could not locate a physician order for the vitamin D level or the follow-up appointments for urology. LPN1 stated typically when a resident was readmitted to the facility, the admissions nurse will transcribe the hospital physician orders and enter them into the EMR. LPN1 stated that any follow-up medical appointments would then be scheduled. During a subsequent interview on 10/30/24 at 8:33 AM, LPN1 confirmed again there was not an order for a vitamin D level for R1. LPN1 stated the physician hospital orders carry over to the facility to implement. LPN1 stated all the medical appointments were then placed in an appointment book, and since R1's family member was involved in his care, the facility coordinated with the family since the family member typically met the resident at his medical appointments and the facility provided the transportation. During an interview on 10/30/24 at 3:07 PM, Registered Nurse (RN) 2 stated he did not remember the readmission of R1 on 08/14/24. The Director of Nursing (DON) was present during this interview and stated she was confused about the orders from R1's hospitalization upon readmission. She stated she just made the urology appointment for R1 for 11/05/24. The DON stated it was her error in the interpretation of the hospital discharge summary. During an interview on 10/31/24 at 9:08 AM, the DON stated her expectation was for the admitting nurse to review the hospital discharge summary, to schedule the appointments for a resident, and place this information in the schedule book. The DON stated the management team would then ensure the appointments were scheduled and discussed in the morning meetings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, interviews, and review of the facility's policy, the facility failed to ensure one of nine sampled residents (Resident (R)1) had a bowel program implemented. This deficient practice may result in bloating, pain, and general discomfort. Findings include: Review of a facility policy titled, Bowel Elimination Protocol, dated 09/2024, indicated, .CNAs [Certified Nurse Aides] are responsible for documenting bowel movements and for asking alert residents who toilet themselves about their elimination each shift . Residents who have had no BM (bowel movement) for 72 hours will be considered for pharmacological intervention or increased non-pharmacological intervention. Additional information related to elimination may need to be gathered . e.g. bowel sounds. Review of R1's electronic medical records (EMR) titled Admission Record, located under the Profile tab, indicated the resident was admitted to the facility on [DATE]. Review of R1's EMR titled Clinical Physician Orders, located under the Orders tab, indicated physician ordered Senna Oral Tablet 8.6 milligrams (mg), give two tablets by mouth every 12 hours as needed for constipation. In addition, the physician ordered MiraLax oral powder 17 grams (gm) per scoop every 24 hours as needed for constipation. Review of R1's EMR titled admissions Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/24/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of six out of 15, which revealed the resident was severely cognitively impaired. The assessment indicated the resident had an impairment on one side of his upper and lower extremities. The assessment indicated the resident required substantial/maximal assistance from staff for toileting. The assessment indicated the resident was always incontinent of bowel. Review of R1's EMR titled Care Plan, located under the Care Plan tab and dated 05/17/24, indicated the resident had a deficit with activities of daily living, specifically with toileting and required staff to provide the resident with extensive assistance. Review of a document provided by the facility titled, Bowel Function, for the month of 07/2024, failed to contain evidence that R1 had a bowel movement from 07/20/24 through 07/24/14. There was no evidence that the resident had a bowel movement from 07/28/24 through 07/31/24. Review of R1's EMR titled, Medication Administration Record (MAR), for the month of 07/2024, indicated the resident was not administered the bowel protocol from 07/20/24 though 07/31/24 and from 07/28/24 through 07/31/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 8:33 AM, Licensed Practical Nurse (LPN) 1, who was also the Unit Manager for the Third Floor, stated the facility was to provide the bowel protocol after three days. LPN1 stated R1 was incontinent of bowel and bladder. LPN1 reviewed the EMR for R1 and verified the bowel protocols orders were not implemented. An interview was conducted on 10/30/24 at 9:21 AM with the Director of Nursing (DON) and Regional Nurse Consultant. The DON stated the CNAs' s documentation was not accurate. The DON stated the CNAs were not documenting accurate information on R1's BMs. During an interview on 10/30/24 at 2:51 PM, LPN3 stated it was important for staff to document a resident's BMs to address the potential of a bowel obstruction.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, observation, staff interviews, and facility policy review, the facility failed to assess nutritional status after a significant weight gain and loss and failed to take corrective action after the facility determined the weight gain and loss was an error for one of one resident (Resident (R) 1) reviewed for nutrition in a total sample of nine residents. Findings include: Review of a facility policy titled, Weight Monitoring Program, dated 09/29/23 indicated . Each resident's weight will be monitored consistently and closely by the interdisciplinary team. All residents with patterned or significant weight changes will be assessed by the facility's interdisciplinary team as indicated. Interventions to address nutritional issues will be initiated and incorporated into the resident's care plan and re-evaluated on a timely and periodic basis . The IDT is responsible for reviewing weights, notifying appropriate disciplines of significant changes, initiating corrective actions and completing documentation . If the resident's significant weight loss/gain is explainable (i.e. weight reduction program, dialysis, diuretic therapy), documentation must be entered into the resident's medical record to support this determination, with appropriate revisions to the care plan and addressed with the IDT team . Review of R1's electronic medical records (EMR) titled Admission Record, located under the Profile tab, indicated the resident was admitted to the facility on [DATE]. Review of R1's EMR titled hospital Discharge Summary, located under the Misc (Miscellaneous) tab and dated 05/17/24, revealed the resident's weight was 159.2. Review of R1's EMR titled Weights Summary, located under Weights & Vitals tab and dated 05/17/24, indicated the resident weighed 159.2. Review of R1's EMR titled Care Plan, located under the Care Plan tab and dated 05/23/24, indicated the resident was at risk for alterations in nutrition, and the intervention directed the facility to weigh the resident every month or per physician/Registered Dietician (RD) order and to document and notify the physician or RD of any significant weight changes Review of R1's EMR titled Mini Nutritional Assessment, located under the Note tab and dated 05/23/24, indicated the resident scored eight out of 14 and determined the resident was at risk of malnutrition. Review of R1's EMR titled Nutritional Assessment, located under the Note tab and dated 05/23/24, indicated the RD indicated the facility was to monitor weights as ordered. Review of R1's EMR titled Clinical Physician Orders, located under the Orders tab and dated 05/24/24, indicated the physician ordered to weigh the resident once a week for four weeks and then monthly. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's EMR titled, Weights & Vitals, located under the Weights & Vitals tab, indicated the following resident's weights: on 05/17/24 he weighed 159.2; on 05/24/24 he weighed 161.2; there were no weights taken for the month of 06/2024; 07/11/24 he weighed 152.0; on 07/21/24 he weighed 156.2; on 08/14/24 he weighed 173.0 and next to this weight it stated that it was the resident's hospitalization weight. On 09/19/24, RD1 crossed this weight out, due to the weight being inaccurate. The resident was then reweighed at 164.5 and was weighed in his wheelchair. Finally, on 10/18/24, the resident weight was 148.7 pounds. This was a 9. 6 percent weight loss (15.8 pounds) in one month, from 09/19/24 through 10/18/24. Review of R1's EMR titled quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 08/23/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of six out of 15, which revealed the resident was severely cognitively impaired. The assessment indicated the resident had an impairment on one side of his upper extremity. The assessment revealed the resident weighed 173 pounds. The assessment indicated the resident had a significant weight gain. There was not a corrected assessment completed after this date. Review of R1's EMR titled Mini Nutritional Assessment, located under the Note tab and dated 08/24/24, indicated the resident scored eight out of 14 and determined the resident was at risk of malnutrition. During an observation on 10/29/24 at 12:14 PM, R1 was in the dining room. There were multiple staff present. R1 stated the food was very good. At 12:21 PM, the resident was served his regular meal of baked chicken thigh with a leg, steak fries, bread, canned fruit, and a glass of lemonade. At 12:55 PM, the resident completed his entire meal. During an interview on 10/30/24 at 8:33 AM, Licensed Practical Nurse (LPN) 1, who was also the Unit Manager for the Third Floor, stated R1 was a good eater, and weights were to be done on a monthly basis. LPN1 confirmed the resident was not on a diuretic. LPN1 reviewed the resident's EMR during this interview and stated the resident was not re-weighed when there was a change in his weight. LPN1 stated more than likely, the staff did not subtract the weight of the resident's wheelchair during the weight taken on 09/19/24. LPN1 confirmed she took the resident's weight and recorded it on 10/18/24. LPN1 stated she subtracted the weight of the wheelchair, so he had an accurate body weight. During an interview on 10/30/24 at 10:19 AM, RD1 stated she came to the facility on e time per week. RD1 stated she typically did not reference the hospital weight on a resident since hospitals tend to use bed scales and there can be a 30-pound variance. RD1 stated she was not the person who placed R1's weight of 173 pounds in the EMR. RD1 stated the quarterly assessment for nutrition was completed by RD2, and she was a subcontractor. RD1 stated she was the person who crossed out R1's weight on 08/14/24. RD1 stated RD2 was responding to a significant weight gain for the resident per the quarterly assessment. As for the resident's weight loss, the RD1 stated if the resident had an actual weight loss, she would have recommended a supplement, and these recommendations would be placed in the resident's progress notes. A telephone message was left on 10/30/24 at 12:01 PM for RD2, and there was no return call received prior to the exit of the survey. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 1:45 PM, the Administrator stated the RD sends over a report of any outrageous weight changes. The Administrator stated the facility was still old school and was trying to get staff to enter the weights in the EMR and not document weights on paper. During an interview on 10/31/24 at 9:08 AM, the Director of Nursing (DON) stated her expectation was for the staff to re-weigh a resident if there was a weight different. The DON confirmed the weights varied for R1 and stated re-weights should have been done. She stated if there was an accurate weight loss, then staff would contact the RD, and the RD would make recommendations such as supplements or double portions of food. The DON stated the physician or the Nurse Practitioner (NP) would then be contacted.