STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525616	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads Care Center of Mayville	305 S Clark St Mayville, WI 53050

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** 21855 Based on record review and interview, the facility did not ensure a resident had a neurological assessment after potential head injury and was comprehensively assessed prior to being transferred to the hospital. This was observed with 1 (R104) of 15 residents reviewed. * R104 had 2 unwitnessed falls without consistent completion of a neurological assessment. * R104 family requested R104 to be transferred to a hospital for evaluation on 7/3/24. There is not documentation of R104 clinical status. or physician order, prior to being transferred to the hospital. Findings include: The facility's policy and procedure Neurological Assessment, revision date 9/25/2023, was reviewed by Surveyor. The policy states Residents will have a neurological assessment completed when they experience a head injury, have an unwitnessed fall or a change in condition that deems it necessary or per physician order. The procedures include Observe, assess and document the resident's level of consciousness, speech, pupils, hand grasps and vitals signs. Neuro checks are completed following a schedule using an assessment tool that outlines said schedule. R104 was admitted to the facility on [DATE] with a diagnosis of (TBI) Traumatic Brain Injury with a subarachnoid hemorrhage. R104 has an Guardian for decision making. The Nursing Admission assessment, completed 6/29/24, at 12:50 PM, assesses R104 as a fall-risk. On 6/29/24, at 4:15 PM, R104 has an unwitnessed fall in the hallway. The Fall Incident form documents, Was self ambulating in hallway and unable to state what happened. The Neurological Assessment Flowsheet documents: neurological assessment every 15 minutes x4, then every 30 minutes x4, then every 1 hour x4, then every 4 hours x4, then every 8 hours x3. The assessment includes areas to document vital signs, pupils, motor function, level of consciousness, pain response and other. R104's Neurological Flowsheet does not have an assessment for: 6/29/24, at 6:00 PM and 6:30 PM with a documented reason being, due to on the phone with family, 6/30/24, 7:00 AM and 6/30/24, at 3:00 PM. (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	On 7/3/24, at 12:00 PM, R104 had an unwitnessed fall from their bed. The Fall Incident form documents Resident was looking for their brother and thought they slid out of bed. The Neurological Assessment Flowsheet documents: neurological assessment every 15 minutes x4, then every 30 minutes x4, then every 1 hour x4, then every 4 hours x4, then every 8 hours x 3. R104's Neurological Flowsheet does not have an assessment for: 7/3/24 at 12:45 AM, 1:00 AM, 1:30 AM, 2:00 AM, 2:30 AM, 3:00 AM and 4:00 AM, documented reason being, due to sleeping; 7/3/24, at 5:00 AM, 6:00 AM and 7:00 AM due to R104 refused. The Nurses Notes document on 7/3/24, at 11:56 AM, Resident leaving the facility to be evaluated at the hospital per family request. There is no documentation of a comprehensive clinical assessment of R104's status prior to being transferred. On 8/14/24, at 3:14 PM, Surveyor requested any information regarding R104's neurological assessments, and transfer assessment, from Nursing Home Administrator (NHA)-A, Director of Nurses (DON)-B, Consultant-D and Consultant-E. On 8/15/24, at 9:15 AM, NHA-A and Consultant-E spoke with Surveyor. NHA-A stated The nurse was talking to R104's family on 6/29/24 and could not end the conversation to complete the neurological assessments. On 7/3/24 the nurse did not want to wake R104 due to being agitated earlier in the shift. Surveyor noted R104 was admitted to the facility with a diagnosis of TBI with hemorrhage. R104 would be at a high-risk for any neurological changes. NHA-A and Consultant-E agreed. On 8/15/24, at 10:52 AM, DON-B spoke with Surveyor regarding an assessment prior to transfer to the hospital. DON-B stated R104's family wanted a different facility and there was not a change in condition on 7/3/24. DON-B did not provide documentation related to R104's clinical status, or physician order, prior to R104 being transferred to the hospital.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 21855 Based on record review and interview, the facility did not complete thorough investigations of resident falls, and identify and implement revisions to the plan of care to prevent future falls. This was observed with 1(R104) of 2 residents reviewed with falls. *R104 had falls on 6/29/24, 7/2/24 and twice on 7/3/24. There was no documentation of a comprehensive assessment to determine causative factors. The Facility does not thoroughly investigate F104's falls to determine the root cause nor implement fall prevention interventions based on the identified root cause to prevent future falls. Findings include: The facility's policy and procedure entitled, Accidents/Fall Prevention Program, dated 1/30/2023, was reviewed by Surveyor. The policy documents: The facility strives to promote safety, dignity and overall quality of life for its residents by providing an environment that is free from any hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents. Any episode of a fall should be documented in risk management. Each fall must be investigated and/or assessed using a root cause analysis process to determine the cause of the fall and prevent any further injury. The individual care plan is to be updated with any changes or new interventions post fall and communicated to staff and implemented. R104 was admitted to the facility on [DATE], at 12:50 PM with a diagnosis of TBI (Traumatic Brain Injury) with subarachnoid hemorrhage. R104 has a Guardian for decision making. The Admission Nursing Assessment conducted on 6/29/24, at 12:50 PM, assesses R104 as a fall risk. Surveyor notes R104 was at the facility from 6/29/24 through 7/3/24 and had 4 falls during this time. R104 discharged prior to the completion of an Admission Minimum Data Set (MDS) assessment. The initial plan of care for Fall Risk dated 6/29/24, with a resolved date of 7/1/2024, with a goal date of 9/27/2024 documents interventions dated 6/29/24: Call light within reach; Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; Ensure proper footwear; Follow facility fall protocol. The initial plan of care for ADL (activity of daily living) self-care performance deficit due to TBI with weakness, and poor impulse control, which increases risk for complications, such as falls and incontinence, dated 6/29/24 with revisions on 7/1/24, 7/5/24 and 7/8/24, and a goal date of 9/27/2024, was reviewed. The interventions documented: 7/1/24 provide adequate adaptive equipment necessary during transfer; toilet riser in bathroom; encourage to use call light; wheelchair with anti-rollbacks; 7/2/24 an intervention of do not leave alone in room. There is a revision date of 7/5/2024 with no changes in interventions. There is a revision date of 7/8/2024 with interventions: bariatric bed with bolsters and extender; call family and allow them to talk as this helps decrease agitation; encourage resident to stay in the common area when awake. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Kardex for staff care printed 8/14/2024, includes under Resident Care: call family and allow them to talk as this helps decrease agitation; encourage resident to stay in the common area when awake. The Kardex does not identify fall risk interventions for safety. FALLS * On 6/29/24, at 4:15 PM, R104 had an unwitnessed fall in the hallway. The fall documentation includes, improper footwear and ambulating without assistance. There is not a comprehensive assessment to determine causative factors to identify what R104 was doing at the time of the fall, when they were last assisted by staff and to support the immediate intervention of R104 to be placed in a wheelchair by the nurses station, then after supper, was transferred to a low bed, in their room. The initial plan of care for fall risk dated 6/29/24, with a resolved date of 7/1/2024, with a goal date of 9/27/2024, documented interventions starting 6/29/24 include to ensure proper footwear. Surveyor notes the fall was not thoroughly investigated to include causative factors leading up to the fall, along with identification of fall prevention interventions related to possible causative factors. On 8/15/24, at 9:15 AM, (Nursing Home Administrator) NHA-A provided additional fall investigation information that is not part of the medical record. The supplemental fall investigation information documented R104 was last toileted at 3:00 PM, had socks on and was not using an assistive device when they fell on [DATE]. The intervention was to keep in a common area. * On 7/2/24, at 3:10 PM, R104 had an unwitnessed fall in their room. The fall incident does not include a comprehensive assessment of causative factors leading up to the fall. The initial plan of care for ADL (activity of daily living) self-care performance deficit due to TBI with weakness and poor impulse control which increases risk for complications such as falls and incontinence, dated 6/29/24 with revisions on 7/1/24, 7/5/24 and 7/8/24, and a goal date of 9/27/2024, was reviewed; The interventions: 7/1/24, provide adequate adaptive equipment necessary during transfer; toilet riser in bathroom; encourage to use call light; wheelchair with anti-rollbacks. On 8/15/24, at 9:15 AM, NHA-A provided additional fall information that is not part of the medical record which documented R104 was in an activity prior to the fall. The activity staff took R104 to their room to use the bathroom. The staff left R104 in their room to get staff to assist with toileting. The staff was re-educated to review Kardex for fall interventions. Surveyor notes R104's Kardex does not identify R104 as a fall risk or provide instructions to not leave R104 alone in their room. The Kardex does not document fall prevention interventions. The ADL plan of care does documents on 7/3/24: do not leave R104 alone in room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 7/3/24, at 12:00 PM, R104 had an unwitnessed fall from bed. The fall incident does not document a comprehensive assessment to determine causative factors, along with interventions to prevent further falls. The fall incident report documents R104 was looking for their brother and was put to bed a few minutes prior to the fall. The immediate intervention implemented was 15 minute checks and transferred back to bed. Surveyor notes there is no comprehensive assessment to determine causative factors leading up to the fall to determine appropriate interventions to prevent further falls. On 8/15/24, at 9:15 AM, NHA-A provided additional fall information that is not part of the medical record. There was no information for possible causative factors leading up to the fall. The interventions were 15 minute checks. Surveyor notes there are no plan of care changes for 7/3/2024 fall and prevention. * On 7/3/24 at 6:40 AM R104 had a fall with staff present. R104 was urinating on the floor as they were walking to the bathroom. The staff was not able to use a gait belt for assistance, R104 legs become weak and they fell to the floor. There is not a documented comprehensive assessment to assess for injury, There was no immediate intervention documented related to this fall. Surveyor notes the fall care plan does not address R104's 4 falls. The initial plan of care for ADL(activity of daily living) self-care performance deficit due to TBI with weakness and poor impulse control which increases risk for complications such as falls and incontinence, dated 6/29/24 with revisions on 7/1/24, 7/5/24 and 7/8/24, and a goal date of 9/27/2024, was reviewed; The interventions: 7/1/24 provide adequate adaptive equipment necessary during transfer; toilet riser in bathroom; encourage to use call light; wheelchair with anti-rollbacks. On 7/2/24 an intervention of do not leave alone in room was added. On 8/15/24, at 9:15 AM, NHA-A provided additional fall information that is not part of the medical record. There was not documentation related to a comprehensive assessment of R104 at the time of the fall. There was no documentation of immediate interventions to prevent further injury. On 7/3/24 at 11:56 AM R104 family requested R104 to be transferred to the hospital. R104 did not return back to the facility. Surveyor informed Nursing Home Administrator-A R104's falls were not comprehensively assessed to identify a root cause analysis, along with appropriate fall prevention interventions identified and R104's care plan revised.

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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** 21855 Based on record review and interview, the facility did not ensure a resident received a prescribed medication as ordered by the physician. This was observed with 1 (R104) of 6 resident medication reviews. * R104 hospital discharge medication orders were not transcribed correctly upon admission to the facility. R104 did not receive the prescribed medication as directed by the physician. Findings include: R104 was admitted to the facility on [DATE] from the hospital. R104's hospital discharge summary dated 6/29/2024, documents propranolol10 mg (milligram) at breakfast and lunch. There is not a diagnosis indicated with this medication. The hospital history and physical includes propranolol prescribed for tremors. R104 history and physical paperwork does not include documentation of diagnoses of hypertension. The facility physician orders, on 6/29/24, documents propranolol 10 mg daily for hypertension. Surveyor notes the order was transcribed incorrectly and was only ordered daily vs the prescribed 2 times daily. The June (Medication Administration Record) MAR, indicates propranolol 10 mg one time a day for hypertension. This is documented as being administered on 6/30/24 at 6:30 AM. The July MAR, indicates propranolol 10 mg daily for hypertension. This is documented as being administered on 7/1/24 - 7/3/24, at 6:30 AM. On 8/14/24, at 3:14 PM, Surveyor, requested any information related to R104's propranolol prescription, during the daily exit meeting with Nursing Home Administrator (NHA)-A, Director of Nurses (DON)-B, Consultant-D and Consultant-E. On 8/15/24, at 9:15 AM, NHA-A and Consultant-E spoke with Surveyor and provided a Medication Occurrence form. Consultant-E stated the Assistant Director of Nurses (ADON)-C caught the prescription error during a 2nd check of admission orders. They thought it was saved in the computer. Consultant-E stated DON-B inputs the medication orders into the computer first and then there is a 2nd check of the orders and ADON-C thought the propranolol order was saved in the computer. The Medication Occurrence form, dated 7/3/24, documents, the medication was clarified to be for tremors, the nurse practitioner was updated, this was discovered after R104 was transferred out of the facility. Surveyor informed NHA-A and DON-B of the concern R104 did not receive the correct medication order at the facility.