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	02/21/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately for 2 of 6 residents (R) reviewed for abuse (R5 and R6). The facility did not report a resident-to-resident altercation that occurred between R5 and R6. This is evidenced by: (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Freedom from Abuse, Neglect, and Exploitation, undated, states in part: It is the policy of this community to take appropriate steps to prevent the occurrence of: Abuse . It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse .are reported immediately to the administrator of the community .such violations are also reported immediately to state agencies in accordance with existing state law. The community investigates each such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to state agencies and Adult Protective Services as required by state and federal law . Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents . Resident to Resident Altercations: An incident involving a nursing home resident who willfully inflicts injury upon another resident. Willful means the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm . Prevention: The administrator and director of nursing services (DON) identify, intervene, and correct in situation in which abuse, neglect, or misappropriation of resident property is more likely to occur . Identification: Incidents of possible abuse or neglect .will be identified through ongoing assessment of resident conditions, incidents, resident interviews, family or resident councils, and verbal or written report of observations . Investigation: .The administrator, director of nursing, or designee will notify the appropriate regulatory, investigative or law enforcement agencies immediately, in accordance with state regulations. Allegations of abuse, neglect, or exploitation will be thoroughly investigated. The investigation will be initiated upon receipt of the allegation. The administrator, or designee, will complete the investigation process. The investigation can include, but is not limited to i. The name(s) of the resident(s) involved ii. The date and time the incident occurred iii. The circumstances surrounding the incident iv. Where the incident took place v. The names of any witnesses vi. The name of the person(s) alleged with committing the act . Reporting: . The administrator notifies the appropriate state agency immediately in accordance with state law. The results of all investigation are reported to the administrator and to the appropriate state agency . The administrator, or his/her designee, notifies the resident's representative regarding the alleged violation and assessment findings and reassures the resident's representative that an investigation has been initiated and appropriate action will be taken. R5 admitted to the facility on [DATE] with diagnoses including anxiety disorder and depression. R5's Brief Interview for Mental Status (BIMS), dated 2/6/25, has a score of 15, indicating R5 is cognitively intact. R6 admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, anxiety, mood disorder, and cognitive communication deficit. R6's Brief Interview for Mental Status (BIMS), dated 12/30/24, has a score of 10, indicating R6's cognition is moderately impaired. R6's comprehensive care plan printed on 2/21/25, states in part: Focus: The resident has a behavior problem. Interventions: Intervene as necessary to protect the rights and safety of others. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/25 at 11:09 AM, Surveyor interviewed CNA C (Certified Nursing Assistant) regarding abuse. CNA C indicated a resident-to-resident altercation is abuse. CNA C indicated a resident swearing, name calling, or threatening another resident is abuse. CNA C stated R6 said you're a nosey bitch to R5 while CNA C was in the room. CNA C indicated this happened within the past 2 days. Of note, R5 and R6 share a room. On 2/21/25 at 2:10 PM, Surveyor spoke with NHA A (Nursing Home Administrator) regarding this incident. NHA A stated she was aware of the incident and did not report this incident as abuse to the state agency. NHA A stated she followed Resident-to-Resident Altercation Flowchart and decided to not report this incident. NHA A stated R5 was unbothered by the comment. Of note, the Resident-to-Resident Altercation Flowchart states in part: resident to resident altercation occurs - did resident act willfully? Willful means the individual's act was deliberate- not inadvertent or accidental regardless of whether or not the individual intended to inflict injury or harm. (A resident whose involuntary movements cause him/her to accidentally strike another has not committed a willful act.) if the no option is selected, do not report. Document an immediate assessment and lack of willful intent. Assess-care plan-intervene. Goal: Prevent reoccurrence and keep other residents safe. Also, the flowchart states Use of this flowchart must provide for immediate reporting (see F609) or the facility must clearly document the rationale for not reporting. It should be noted using the reasonable person concept a person would not be expected to be called names or swore at in their own home and may experience fear from such encounter. Surveyor requested R5 and R6's electronic health records documenting this incident including any assessments, nurses' progress notes, updated care plan, etc. Surveyor was not provided any electronic health records documenting the investigation of this incident. Of note there was no evidence the facility documented an immediate assessment and a lack of willful intent. Assessed R5 and R6's-care plan- intervened or implemented interventions to prevent reoccurrence and keep other residents safe.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review the facility did not develop a comprehensive, person-centered care plan for 1 of 6 sampled residents (R3) reviewed for person-centered care plans. R3 does not have a comprehensive care plan that includes triggers and monitoring targetd behaviors. Evidenced by: Facility policy entitled Comprehensive Care Plans, dated 1/25, states, in part; It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care.3. The comprehensive care plan will describe, at a minimum, the following: . f. Resident specific interventions that reflect the resident's needs and preferences . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (minimum data set) assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.8. Qualified staff responsible for carrying out interventions specified in the car plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Example 1 R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Dementia in other diseases classified elsewhere, unspecified severity, with psychotic disturbance, Anxiety disorder, unspecified, Major Depressive disorder, recurrent, unspecified, and Need for Assistance with personal care. R3s most recent Minimum Data Set (MDS) dated [DATE] states that R3 has a Brief Interview of Mental Status (BIMS) of 12 out of 15, indicating that R3 has mild cognitive impairment. R3's Comprehensive Care Plan states, in part: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: The resident demonstrates a pattern of situational and/or coping problems in areas such as: being alone after her spouse leaves. Psychosocial well-being, Mood state and/or behavioral symptoms. Date initiated 10/21/22. Revision on 7/1/24. Goal: The residents mental health and psychosocial well-being will be enhanced: staff encouragement, reminders of how well she is doing. Date initiated 10/21/22. Revision on 9/19/24. Interventions: Encourage the resident to express her thoughts and feelings. Date initiated 10/21/22. Help the resident feel welcome, accepted, acknowledge and well-received. Provide structure and guidance to help the resident feel safe, competent, involved, secure, valued, and appreciated. Work to help the resident develop a role that provides him/her with a sense of purpose and builds esteem/worth. Date initiated 10/21/22. Focus: The resident has an active order for anti-anxiety medication due to Anxiety disorder. Date Initiated 8/19/22. Revision on 8/19/22. Goal: The resident will be free from discomfort or adverse reaction to anti-anxiety therapy through the review date. Date initiated: 8/19/22. Revision on 9/19/24. Interventions: Administer anti-anxiety medications as ordered by physician. Date initiated 8/19/22. Monitor/document/report PRN (as needed) any adverse reactions to anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Date initiated 8/19/22. Provide re-assurance if resident becomes anxious. Allow her to express herself, offer to call her husband. Date initiated 12/10/24 . Focus: The resident has an active order for antidepressant medication for Depression. Date initiated 9/17/24. Revision on 9/17/24. Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Date: 9/17/24 isolation, suicidal thoughts, withdrawal, decline in ADL (Activities of Daily Living) ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes. Date initiated 9/17/24. Provide reassurance if resident expresses sadness. Encourage her to think about things she enjoys like her visits with her husband and looking at animals outside her window. Date initiated 12/10/24. R3's Progress Notes, state in part: On 10/1/24 at 2:02 PM, Type: Behavior Note: During shower resident called CNA (Certified Nursing Assistant) a bitch several times and hit CNA in her right arm x2. CNA able to complete shower, no further issues. On 11/24/24 at 8:32 AM, Type: Behavior Note: Resident continues to refuse medications in the morning in an aggressive way. She never just states that she does not want it. She yells, sometimes swears, sometimes demands staff to get out. This is not just on the NOC (nocturnal, overnight) shift but have heard that this is happening on staff on the PM shift as well and she is not getting her important meds. Writer has noticed that she has been getting some of the Parkinson's effects of the tremors while drinking and just lying in bed. When I have brought this to her attention, she always states to me BULLS*** several times. She is also being non-compliant with wanting to be turned for her coccyx/sacrum wound while lying in bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 11:01 AM, Type: Behavior Note: Resident refuses shower after three attempts by three different people. Resident started to raise her voice and become extremely agitated after final attempt. On 12/21/25 at 1:37 AM, Type: Behavior Note: Resident has been acting out at night. She has been pushing the call light continuous at times stating that she is sinking. All CNA and RN (Registered Nurse) has checked the bed and the alarm on the bed is not going off. Today CNA went into check/change her and she slapped her. She has been getting more and more physical with the staff regarding cares. On 2/21/25 at 5:45 AM, Type: Behavior Note: Resident again, with the nurse helping to provide cares tried to kick the CNA a couple of times while changing her. The CNA asked her not to do that and the resident responded I can if I want to. The RN corrected her and stated NO, you can not. You should not be hitting anyone. On 2/21/22 at 2:22 PM, Surveyor interviewed CNA G (Certified Nursing Assistant) and asked her about R3's behaviors. CNA G stated she has heard of R3 being aggressive with other staff members but never with her. CNA G stated that R3 can become resistive with cares and refuse medications at times. Surveyor asked CNA G what interventions were in place for R3's behaviors. CNA G stated that she will reapproach, not push her, and back off. Surveyor asked CNA G where R3's behaviors and interventions would be listed. CNA G stated they would be in the care plan and CNA Kardex. On 2/21/24 at 2:27 PM, Surveyor interviewed RN D (Registered Nurse) and asked her about R3's behaviors. RN D stated that R3 refuses cares and yells a lot, and that she does attempt to hit and kick with cares. Surveyor asked RN D what interventions were in place for R3's behaviors. RN D indicated that she attempts redirection or distraction, or will step away and let a new face reapproach. RN D indicated that when R3 is agitated, they do cares in pairs, meaning that two staff will go into R3's room together to provide cares. RN D stated that R3 becomes triggered when her husband is not here, that he comes twice a day but when he leaves R3 gets more agitated. Surveyor asked RN D where these behaviors, triggers, and interventions would be listed. RN D stated they would be in R3's care plan. On 2/21/25 at 2:11 PM, Surveyor interviewed CNA H and asked her about R3's behaviors. CNA H stated that R3 will refused cares a lot and get confused. CNA H stated that R3 doesn't like to be touched or messed with too much. CNA H stated that R3 will say no and become real aggressive. CNA H stated that R3 can become agitated and did try to kick her during cares. CNA H stated that R3's husband comes every day, but she becomes more agitated when he leaves. Surveyor asked CNA H what interventions were in place for R3's behaviors. CNA H stated that she offers R3 food, drink, or tries to change the subject to distract her. CNA H states that R3 likes hot chocolate and various snacks, so she will offer her those. Surveyor asked CNA H if these behaviors or interventions were listed on the CNA Kardex. CNA H stated no, behaviors are not on the Kardex. Surveyor asked CNA H if they were written down anywhere for staff to know how to care for R3. CNA H indicated that staff just know what triggers R3 and what can calm her down. On 2/21/25 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) and asked her if a resident's behaviors would be listed on the CNA Kardex. DON B stated no, behaviors are not on the Kardex. Surveyor asked DON B if a resident's behaviors should be listed on their care plan. DON B stated yes, behaviors should be listed on the care plan, and also that staff would get information related to resident behaviors in shift-to-shift report. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to develop and implement a care plan that described the specific aggressive behaviors that R3 was displaying, nor did they outline triggers or interventions to enable staff to provide quality care to R3.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility did not provide behavioral health services to ensure a resident received the highest practicable mental and psychosocial well-being. The facility did not create a comprehensive assessment and plan of care to address substance use disorder (SUD) for 1 of 2 residents (R2) reviewed for SUDs. R2 has a SUD. The facility failed to create a care plan related to R2's alcohol consumption and failed to implement interventions for behaviors associated with R2's alcohol consumption. This is evidenced by: The facility policy titled Safety for Resident with Substance Use Disorder, dated 1/25, states in part: It is the policy of this facility to create an environment that is as free of accident hazards as possible, for residents with a history of substance use disorder. Definitions: substance use disorder (SUD) is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home . 1. Residents with a history of SUD will be assessed for risks . Care plan interventions will be implemented to include increased monitoring and supervision of the resident and their visitors. 2. When substance use is suspected .facility staff should implement the care plan interventions, which includes notification of the resident's physician or non-physician practitioner. 3. Care planning interventions will address risks by providing appropriate diversions for resident and encouraging resident to seek out facility staff to discuss their plan of care .7. The facility will make an effort to prevent substance use which may include providing substance use treatment services, such as behavioral health services, medication-assisted treatment (MAT), alcoholic/narcotics anonymous meetings, working with their resident and the family, if appropriate, to address goals related to their stay in the nursing home, and increased monitoring and supervision. R2 admitted to the facility on [DATE] with diagnoses including alcohol abuse, repeated falls, unsteadiness on feet. R2's Brief Interview for Mental Status (BIMS) on 11/26/24 has a score of 15, indicating R2 is cognitively intact. R2's Medication administration and Treatment administration records for January 2025 and February 2025 do not include monitoring of behaviors and/or substance use. R2's physician orders dated 2/21/25 does not include an order stating R2 can consume alcoholic beverages. R2's comprehensive care plan dated 2/21/25, states in part: Focus: The resident is functioning at an independent level in his leisure pursuits. Goal: The resident will make one positive statement about his leisure pursuits to staff weekly. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Encourage the resident to pursue appropriate leisure interest on his/her own. Introduce yourself to the resident to establish a friendly and professional rapport. Offer the resident independent leisure materials for him to pursue. Provide the resident with a copy of the activity calendar on a monthly basis. Of note, R2's comprehensive care plan does not include R2's substance use disorder, nor the triggers related to substance use. R2's comprehensive care plan does not include goals related to R2's substance use disorder. R2's comprehensive care plan does not include person-centered interventions to prevent substance use nor mitigate the risks associated with substance use. R2's comprehensive care plan does not include R2's behaviors associated with R2's substance use. R2's nurses' progress notes state: 12/26/25 8:39 AM Resident appears to be intoxicated, smells of alcohol and slurring words. He was in the dining room arguing with other resident and family . 1/17/25 23:31 (11:31 PM) Nurse was called into the resident room for a fall. When Nurse arrived in room resident was getting up and trying to get into the bed. He had one shoe on and one shoe off with a regular sock on the other foot. This was making his foot slip. The CNA quickly assisted him to prevent a further fall, and the nurse assisted with the other side. Resident sat on the side of the bed and allowed the nurse to do a partial assessment. Resident stated that he did not hit his head. He stated that he was OK and that hisprde [sic] is the only thing that is hurt. Resident's BP (blood pressure) is low due to him being intoxicated all other vital signs are WNL (within normal limits) . 1/19/25 10:59 AM Per administration no resident were to go outside for smoking or store runs due to the freezing temperatures. Message was relayed to resident however resident refused to stay inside stating it's not that cold. Resident made multiple trips outside to smoke and went to Kwik Trip. The facility provided an investigation summary related to R2. The summary states in part: On 1/26/25 around 12:00 PM, R2 had a resident-to-resident altercation with R1. R2 threatened to kill R1. It was noted that R2 had been drinking that morning. Staff have noted on many different occasions, empty bottles of alcohol laying around R2's room along with a smell of alcohol coming off R2. On 2/21/25 at 11:19 AM, Surveyor interviewed RN D (Registered Nurse) regarding R2's behaviors. RN D indicated R2 likes to talk like he's tough and will make sexual comments to the staff. On 2/21/25 at 12:39 PM, Surveyor interviewed SSD E regarding R2's substance use, behaviors and his care plan. SSD E indicated R2's substance use, behaviors and interventions should be on the care plan. SSD E indicated there should be a care plan to monitor and intervene with R2's substance use and associated behaviors and R2 does not have a care plan related to substance use or behaviors. On 2/21/25 at 1:00 PM, Surveyor interviewed DON B regarding R2. DON B indicated R2 should have a care plan for his substance use and associated behaviors but does not.