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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48391 Based on interview and record review, the facility did not ensure written notification of coverage change, the financial liability for continued stay, and appeal rights were provided to a Resident (R) whose Medicare Part A benefits were ending for 2 (R45 and R7) of 3 residents reviewed for Medicare Part A notifications. The facility did not provide R45 and R7 with a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) form, which includes, notification of change in coverage, financial liability, and appeal rights. Findings include: Per the Centers for Medicare and Medicaid Services (CMS) Form Instructions, the SNFABN provides information to the beneficiary so that he or she can decide whether to get the care that may not be paid for by Medicare and assume financial responsibility. The SNFABN includes information such as the care that may or may not be covered by Medicare, the estimated cost of the corresponding care that may not be covered by Medicare, and appeal options. Surveyor reviewed a sample of residents for Medicare Part A notifications. Surveyor noted two of three sampled residents, R45 and R7, remained at the facility following termination of Medicare Part A coverage. The facility only provided Surveyor with Notice of Medicare Non-Coverage (NOMNC) forms for both R45 and R7. On 08/15/24, at 10:46 AM, Surveyor spoke with Nursing Home Administrator (NHA)- A who indicated R45 and R7 did not receive SNFABN. NHA- A states the previous social worker was responsible for the SNFABN form and did not provide to R45 and R7. NHA- A indicates facility staff have changed and they have since resolved the concern. There is coverage now for these notices.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observation, interview, and record review the Facility did not ensure 1 (R7) of 2 residents were provided privacy during personal cares. *R7 informed Surveyor staff will leave R7's window drapes open when providing personal cares. R7's window is next to a public patio area and R7 would like R7's privacy when personal cares are provided. *Surveyor observed staff leave the window drapes open while providing cares to R7. Findings include: R7 was admitted to the facility on [DATE] with diagnosis that include Type 2 Diabetes, Depression, Muscle weakness, and Lymphedema. R7's Quarterly Minimum Data Set (MDS) dated [DATE], documents R7 is cognitively intact. R7 is frequently incontinent of bowel and bladder and is dependent for toileting. On 08/12/2024, at 10:25 AM, Surveyor interviewed R7. R7 informed Surveyor R7 would prefer that his window curtains be closed when staff change R7's brief. R7 stated R7's window is off a shared, public patio. R7 indicated R7 does not like the fact that people can see in his room when R7 is receiving personal and private cares. On 8/14/2024. at 8:45 AM, Surveyor observed Certified Nursing Assistant (CNA)-F exiting R7's room with a sit to stand lift (EZ stand). Surveyor asked why CNA-F was in R7's room with the EZ stand. CNA-F indicated R7 needed R7's incontinence product changed, and personal cares completed. Surveyor asked CNA-F if the window curtains were closed prior to providing cares to R7. CNA-F stated No. CNA-F stated that CNA-F has asked R7 in the past if R7 wanted the window curtains closed and R7 told CNA-F that R7 did not care. CNA-F stated, I guess I could ask each time, but I didn't. On 8/14/24, at 8:52 AM, Surveyor interviewed R7. Surveyor asked R7 if CNA-F provided personal cares. R7 stated yes. Surveyor asked if the window curtains were closed. R7 stated No. Surveyor asked if R7 wanted the window curtains closed, R7 stated yes but at least there is no one on the patio at this time. On 8/14/2024, at 10:43 AM, Surveyor noted R7's call light was on. Surveyor observed Registered Nurse (RN)-G enter R7's room with the EZ stand. At 10:46 AM, Surveyor observed Director of Nursing (DON)-B enter R7's room. At 10:47 AM, Surveyor knocked on R7's door and observed R7 assisted by RN-G and DON-B in the EZ stand. The window curtain was open. RN-G and DON-B indicated they were doing cares. Surveyor closed the door. At 10:49 AM, Surveyor walked to the public patio located right outside of R7's window. Surveyor noted that R7's window drapes were open and R7's room was visualized from the public patio area. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/2024, at 10:51 AM, Surveyor interviewed R7. R7 stated staff were just in R7's room to change R7's incontinence product. R7 stated the window curtains were open the whole time. R7 stated staff did not ask if R7 wanted the curtains closed or not. R7 stated again that R7 would prefer the window curtains be closed when providing personal cares and opened when the cares are complete. On 8/14/2024, at 10:54 AM, Surveyor interviewed RN-G. Surveyor asked if RN-G was providing personal cares to R7. RN-G stated yes. Surveyor asked if the window drapes were open the whole time while providing care. RN-G stated yes. On 8/14/2024, at 11:22 AM, Surveyor interviewed DON-B and Nursing Home Administrator (NHA)-A. Surveyor informed DON-B and NHA-A that staff was observed providing personal cares to R7 with R7's window curtains open. Surveyor asked if the window curtains should be closed while providing personal care to a resident. DON-B stated DON-B would expect staff to ask the resident if they wanted the window curtains closed. DON-B stated that a lot of residents do not want them closed. DON-B indicated that DON-B was just in R7's room providing personal care. DON-B stated that DON-B asked R7 if R7 wanted the window drapes closed. DON-B stated that R7 stated R7 didn't care. Surveyor informed DON-B and NHA-A that surveyor's concern regarding R7's privacy remains. Surveyor informed DON-B and NHA-A that R7 expressed a preference the window drapes be closed with any personal cares and opened after the cares are complete due to the room being visible from the public patio area. DON-B stated DON-B will add R7's preference to R7's CNA Kardex. No other information was provided as to why the Facility did not ensure R7 was provided privacy during personal cares.

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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** 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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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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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. 21855 Based on record review and interview, the facility did not ensure a resident's indwelling catheter was medically necessary. This was observed with 1 (R13) of 3 residents reviewed with indwelling catheters. * R13 returned from a hospital stay with an indwelling catheter. There were no medical indications for the use of the catheter and it was not removed for 2 months. Findings include: The facility's policy and procedure Catherization of a Resident or Intermittent Catherization, dated 1/30/2023, was reviewed by Surveyor. The policy documents a resident will only be catherized with a physician's order, and medical justification for use, utilizing proper infection control techniques. R13 was readmitted to the facility from a hospital visit on 6/3/24. The Nurses Note on 6/2/24, at 12: 55 AM, documents Writer called Hospital to check up on resident. Resident was admitted with acute respiratory failure. The Nurses Note on 6/3/24, at 6:54 PM, documents Patient sent to hospital 06/01 for sepsis. At hospital was very combative and given Haldol. Patient's family decided to start comfort care. Hospice coming tomorrow to admit. Patient resting back in bed. Also a catheter was placed. Surveyor notes there is no medical justification documented for the use of an indwelling catheter. The Physician Plan of Care documents an order on 6/4/2, Foley Catheter 16 French and 10 cc (cubic centimeter) balloon to gravity drainage. Every shift Foley Catheter Care. No medical diagnosis was documented. A Bowel and Bladder assessment was completed on 6/4/24. This assessment documents, catheter for [R13] cannot make needs known, as well as in the past, and needs to be checked on regularly. Surveyor notes R13 had an indwelling catheter from 6/10/24 -8/1/24 without medical justification. R13 had no urinary tract infections during the indwelling catheter use. R13 passed away on hospice care 8/13/24. On 8/13/24, at 3:00 PM, Surveyor requested any indwelling catheter justification for R13, during the exit meeting with Nursing Home Administrator (NHA)-A, (Director of Nurses) Director of Nursing (DON)-B, Consultant-D and Consultant-E. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24, at 8:51 AM, DON-B spoke with Surveyor. DON-B stated when R13 returned from the hospital, they left it in for comfort, and for Hospice. Then R13, bounced back, and it was removed. Surveyor informed DON-B of the concern R13 had a catheter from 6/10/24-8/1/24 without medical justification.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observation, interviews and record review, the facility did not ensure 1 (R156) of 1 residents reviewed for Dialysis received Dialysis care in accordance with professional standards of practice. *R156 did not have physician's orders for dialysis and there is no evidence staff were assessing and monitoring R156's fistula site on days when R156 did not receive dialysis. Findings include: The facility policy titled, Dialysis Monitoring and Observation dated 5/17/2022, documents, in part: Purpose-To ensure residents receiving hemodialysis are monitored for complications. Monitoring- 1. Listen using a stethoscope for the bruit and thrill of the fistula daily. 2. Document the presence or absence of the bruit and thrill on the [Medication Administration Record (MAR)] or [Treatment Administrations Record (TAR)]. 3. While listening for the bruit and thrill, observe the skin condition for any increased redness or swelling and notify the physician and dialysis center if any present . 10. A care plan will be developed to reflect the need for [Hemodialysis (HD)]. R156 was admitted to the facility on [DATE] with diagnosis that include End Stage Renal Disease (ESRD) with dependence on Renal Dialysis. R156 has an (Arteriovenous Fistula) AV Fistula located in the Left forearm. R156's Admission Minimum Data Set Assessment (MDS) dated [DATE] documents R156 is cognitively intact. R156 requires Dialysis. On 8/14/24, at 1:07 PM, Surveyor observed R156 in bed. Surveyor noted an AV fistula site in R156's left forearm. R156's care plan dated 8/5/2024 documents, Focus: The resident needs dialysis due to ESRD. Goal: The resident will have no [signs/symptoms] of complications from dialysis through the review date. Interventions: Check and change dressing daily at access site. Document (initiated 8/5/2024). Enhanced Barrier precautions (initiated 8/6/2024). Monitor labs and report to doctor as needed (initiated 8/6/2024). Monitor/document/report [as needed] for [signs and symptoms] of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds (initiated 8/6/2024). Surveyor noted the care plan did not address the type of dialysis that R156 receives, did not address R156 has an AV Fistula, and did not address the monitoring of R156's AV Fistula. Surveyor reviewed R156's EMR (Electronic Medical Record) and noted R156 did not have a physician's order for dialysis nor a physician's order to monitor R156's fistula site. Surveyor reviewed R156's MAR and TAR. Surveyor did not locate documentation of R156's AV fistula site being assessed. (continued on next page)

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/2024, at 1:21 PM, Surveyor interviewed Registered Nurse (RN)-G. Surveyor asked if R156 needs an order for dialysis. RN-G stated no. Surveyor asked if staff monitor and document R156's AV fistula. RN-G stated that RN-G does check R156's AV fistula every day when she works. Surveyor asked where the assessment is documented. RN-G stated it is in the MAR or TAR. RN-G opened the Electronic Medical Record (EMR). RN-G did not locate any documentation of monitoring of the AV fistula in R156's MAR or TAR. RN-G stated, They should have it in there. On 8/14/2024, at 1:29 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. Surveyor asked if an order for dialysis is needed. ADON-C stated No. Surveyor asked what physician orders are needed for a resident on hemodialysis. ADON-C indicated they would need an order to check the fistula site. On 8/14/2024, at 1:42 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor asked what physician orders are needed for a resident who needed hemodialysis. DON-B stated there is not an order for dialysis needed, but there should be an order for the type of port/fistula the resident has, where the port/fistula is located and when to document the assessment of the port/fistula. Surveyor asked where the documentation of a fistula assessment would be located. DON-B stated it is in the TAR. Surveyor informed NHA-A and DON-B that R156 did not have an order for dialysis, did not have an order for monitoring of the AV fistula site and that there is no evidence that staff have been assessing R156's AV fistula site on days that R156 did not have dialysis. Surveyor asked how often the AV fistula site should be assessed. DON-B stated it should be assessed every shift. Surveyor noted after the facility was aware of Surveyor's concerns, the following physician orders were added on 8/14/2024: Pre dialysis vitals. Take BP on right arm only one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday). Dialysis access type: Fistula located on the Left arm. Site monitored and intact with bruit/thrill without erythema/edema or bleeding unless otherwise documented. For bleeding: hold pressure directly over the site and notify physician. Every shift. Surveyor noted after the facility was aware of Surveyor's concerns, the following care plan intervention was added on 8/14/2024: Do not draw blood or take B/P (blood pressure) in arm with dialysis site. No further information was provided as to why the facility did not ensure R156 received Dialysis care in accordance with professional standards of practice.

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
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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.