STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525649	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crest Health Center	1702 S River Rd Janesville, WI 53546

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on observation, interview, and record review, the facility did not ensure that self-administration of medications was determined to be clinically appropriate for 1 of 1 residents (R32). R32 was observed with an inhaler sitting on his bedside table. R32 did not have an order to self-administer medications, nor did he have an assessment completed to determine his competency for self-administering medications. This is evidenced by: The facility policy titled, Administering Medications, dated 2001, revision date April 2019, states, in part: Medications are administered in a safe and timely manner, and as prescribed . 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely . R32 was admitted to the facility on [DATE] and has diagnoses that include Chronic Obstructive Pulmonary Disease (COPD), Generalized Anxiety Disorder, Depression Unspecified, Anxiety Disorder Unspecified, Acute Respiratory Failure with Hypoxia (a condition where the body's tissues do not receive enough oxygen), and Shortness of Breath. R32's Minimum Data Set (MDS), dated [DATE], indicated that R32 had a Brief Interview for Mental Status (BIMS) score of 14, indicating R32 is cognitively intact. Section GG of the MDS indicated that R32 requires partial to moderate assistance for all Activities of Daily Living (ADLs). R32's Care Plan, dated 1/10/25, states in part: Focus: The resident has altered respiratory status/difficulty breathing . Intervention: Administer medications/puffers as ordered. Monitor for effectiveness and side effects . R32's Physician Orders include, in part: Albuterol Sulfate Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for shortness of breath, wheezing or cough. Start date: 1/10/25. No end date. A review of R32's Medication Administration Record (MAR) in the electronic medical record for January and February indicated the medication was administered every day without any missed medications. The medication was signed out as being given by the nurses each day. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note: R32 does not have a physician's order to self-administer medications, nor was there a competency assessment anywhere in R32's medical record for self-administering of medications. On 2/10/25 at 10:22 AM, Surveyor interviewed R32 in his room and observed an inhaler sitting on the table next to him. Surveyor asked R32 if he always had his inhaler in his room with him. R32 replied yes, he kept the inhaler at his bedside in case he felt short of breath. R32 indicated he used the same inhaler at home. On 2/11/25 at 4:12 PM, Surveyor interviewed LPN E (Licensed Practical Nurse) about R32's medications. Surveyor asked LPN E what the criteria is for a resident to have medications in their rooms. LPN E stated residents can have medications in their rooms if they are alert and oriented and able to sit up independently. Surveyor asked LPN E if R32 was allowed to have medications at bedside. LPN E replied yes, he was. Surveyor asked LPN E if any assessments had been done to ensure R32's competency for self-administering his own medications. LPN E stated they didn't do any assessments. Surveyor asked LPN E if R32 had a physician's order to self-administer medications. LPN E replied she wasn't sure. LPN E searched her medication cart in Surveyor's presence and could not find an inhaler for R32. LPN E stated, it must be in his room. On 2/12/25 at 11:07 AM, Surveyor interviewed DON B (Director of Nursing) and asked her what her expectation was for a resident to keep medications at their bedside. DON B indicated that if a resident shows interest in wanting to self-administer their own medications, they complete a self-administer assessment that is then reviewed at their weekly risk management meeting. DON B elaborated that if the resident is deemed competent, they would have a lock box given to them to store the medication in their room safely. Surveyor asked DON B who was responsible for completing the self-administer assessments with the resident. DON B replied that it is delegated to the nurses on the unit but that herself and the ADON (Assistant Director of Nursing) are also involved in the process. Surveyor asked DON B if R32 had a self-administer assessment. DON B reviewed R32's electronic medical record and stated that she did not see one. Surveyor asked DON B if R32 had a physician's order to self-administer medications. DON B reviewed his medical record and indicated she did not see one. Surveyor shared her observation of R32 having an inhaler in his room on his bedside table. Surveyor asked DON B if R32 should have a self-administer assessment for competency and a signed physician's order to have medications at bedside. DON B stated yes, he should have those in order to administer his medications independently and safely. The facility's failure to adequately assess and supervise medication administration enabled the resident to keep medications at the bedside and self-administer without demonstrating competency to do so.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44552 Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 58 residents who reside in the facility. Surveyor observed multiple staff wearing hairnets incorrectly. Surveyor observed staff not wearing a beard restraint. Surveyor observed staff enter the kitchenette area while the cook was serving food, not wearing hairnets. The facility policy, Meal Service Delivery from Unit Kitchens, dated February 2025, states, in part; .Hair Restraints .Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Hair nets are required by any employee in the kitchen while food is being prepared or served. All other employees assisting with meal service must have hair pulled back . On 2/10/25 at 11:59 AM, Surveyor observed dietary staff serving food. The dietary staff's hairnet was only covering her hair that was in a bun and the rest of hair was not covered. Surveyor observed 3 different staff go in the kitchenette area while dietary was serving lunch. Surveyor observed staff get items from fridge and wash their hands at the sink while not wearing a hairnet. On 2/10/25 at 12:45PM, Certified Nursing Assistant D (CNA) indicated they do not need to wear hairnets when going in the kitchenette. CNA D indicated the cook who is serving the food needs to wear a hairnet, but not the other staff that are in the kitchenette. On 2/11/25 at 9:06AM, Surveyor observed Dietary Aide I not wearing a beard restraint while working in the kitchen. On 2/12/25 at 8:47AM, Surveyor observed dietary staff serving food. Dietary staff was wearing a hairnet but had her bangs out of the hair net. On 2/11/25 at 9:15AM, Dietary Manager C (DM) indicated staff should wear beard restraints when in the kitchen and provided Dietary Aide I a beard restraint. DM C indicated staff should wear hair restraints properly and it should cover all of hair. DM C indicated if serving and/or cooking is occurring in the kitchenettes, staff should wear hair restraints when in the kitchenettes. If a staff needs something from the kitchenette area when serving is going on the staff should ask the dietary staff for assistance and not go in the kitchenette area. The facility failed to maintain a safe and sanitary environment in which food is prepared, stored, and distributed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on staff interview and record review, the facility did not ensure coordination of care and the hospice communication process was followed for 1 of 2 sampled residents (R61) and 2 of 2 supplemental residents (R55 and R320) for hospice services. R61, R55, and R320 were admitted to hospice services and the facility failed to obtain hospice documentation. Evidenced by: The facility policy titled Hospice Program dated 7/2017 states in part .12. Our facility has designated Social Services to coordinate care provided to the resident by our facility staff and the hospice staff .He or she is responsible for the following: d. Obtaining the following information from the hospice: (1) The most recent hospice plan of care specific to each resident .(4) Name and contact information for hospice personnel involved in hospice care of each resident .(6) Hospice medication information specific to each resident .13. Coordinated care plans for resident receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental, and psychosocial well- being . Example 1 R320 was admitted to the facility on [DATE]. R320 was receiving hospice services at home prior to admission to the facility, and those services continued in the facility. R320's terminal diagnosis is severe protein malnutrition. Surveyor reviewed R320's EHR (Electronic Health Record) and was not able to find any documentation of R320's hospice enrollment, admission assessment, care plan, orders, or visit notes since admission to the facility. Example 2 R55 was admitted to the facility on [DATE]. R55 was receiving hospice services at home and those services continued in the facility. R55's terminal diagnosis is dementia d/t (due to) Parkinson's. Surveyor reviewed R55's EHR (Electronic Health Record) and was not able to find any documentation of R55's hospice enrollment, admission assessment, care plan, orders, or visit notes since admission to the facility. Example 3 R61 was admitted to the facility on [DATE] and signed on to receive hospice services the same day. R61's terminal diagnosis is sepsis. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R61's EHR (Electronic Health Record) and was not able to find any documentation of R61's hospice enrollment, admission assessment, care plan, orders, or visit notes. On 2/11/25 at 3:34 PM, Surveyor interviewed RN F (Registered Nurse). Surveyor asked RN F how the facility receives documentation from the hospice provider, RN F reported that the hospice typically faxes their notes and medical records puts them in the resident's EHR. Surveyor asked RN F to review R61's EHR to locate any hospice notes or documentation. RN F reported that there were no notes scanned in. Surveyor asked RN F if the expectation is that the hospice provider would fax notes to the facility, RN F stated yes. Surveyor asked RN F whose responsibility is it to follow up on the hospice notes, RN F stated that it would be the responsibility of the nurse working the shift. On 2/11/25 at 3:54 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the expectation is for documentation of hospice visits, DON B reported that the expectation is that hospice would complete their assessment and either fax the notes or document in the resident's EHR. Surveyor asked DON B how staff know what the resident's hospice plan of care, visit frequency, and orders are if there is no documentation in the resident's EHR from the hospice provider, DON B states that the hospice nurse communicates each of their visits with the floor nurse or charge nurse. On 2/11/25 at 4:07 PM, Surveyor interviewed RN G (hospice RN). Surveyor asked RN G what the process is when they visit a resident at the facility, RN G states they meet with the resident, and if there are any concerns they will talk to the facility's nurse. Surveyor asked RN G if they fax their notes to the facility or document in the resident's EHR, RN G reported that they do a face to face with the nurse but do not fax their documentation. Surveyor asked RN G how they communicate the care plan with the facility, RN G stated that they only fax it if the facility asks for it. Surveyor asked RN G how the facility knows the frequency of visits, RN G reported that they should know that R61 is seen twice a week for nursing, once a month for Social Worker, and once a week for the Chaplain. Surveyor asked RN G how the facility staff would know that, RN G reported that is should be on the admitting orders. It is important to note that Surveyor reviewed R61, R55, and R320's medical records and there was no documentation of admission orders, admission assessments, nursing visit notes, Social Worker visit notes, Chaplain visit notes or the hospice plan of care. Of note: the facility obtained the appropriate documentation from the hospice provider for R61, R55 and R320 after Surveyor requested it. On 2/12/25 at 10:00 AM, Surveyor interviewed SW H (Social Worker). Surveyor asked SW H what their role is with a resident receiving hospice services, SW H reported that they make the referral, coordinate the initial visit, and update the team regarding the enrollment. Surveyor asked SW H who is responsible for ensuring that the facility receives the hospice visit notes, care plan, enrollment forms, and medication list, SW H reported that the hospice provider faxes the information over, and the documents get scanned into the EHR. SW H reported that they took for granted that they were getting the information and that no one checked.