STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525270	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROSSROADS CARE CENTER OF FOND DU LAC	**115 E ARNDT ST FOND DU LAC, WI 54935**

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

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure a resident POAH (power of attorney for healthcare) and physician were notified of resident change of condition for 1 Resident (R) (R1) of 3 residents reviewed for notifications. R1's physician had ordered scheduled pain medication on 11/27/19. On 12/27/19, it was identified that R1 had not received any of the scheduled doses as ordered. R1's physician and POAH were not notified of this medication error. Findings include: R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's medical record contained a Minimum Data Set (MDS) assessment dated [DATE] which stated R1's Brief Interview for Mental Status (BIMS) score was 99 which indicated R1 had severe cognitive impairment. R1's POAH document contained a Statement of Incapacity signed and dated 11/6/19 which indicated all R1's healthcare decisions were to be made by R1's designated POAH. R1 received Hospice benefits for pain management and end-of-life care. R1 passed away at the facility on 12/30/19. On 8/4/20, Surveyor reviewed R1's medical record which contained a Medication Administration Record [REDACTED]. The 12:00 PM dose on 12/30/19 was documented as held (not given) and the 4:00 PM dose on 12/30/19 was the last dose administered. Surveyor reviewed R1's medical record which contained nursing notes as follows: 12/30/19 at 11:31 AM - Per hospice nurse hold medication patient appears not in any pain and not responsive much at this time. 12/30/19 at 7:46 PM - Writer went to check if the resident was in pain. Writer found that the resident's vital signs had ceased. Writer called hospice and DON (Director of Nursing Services) to inform. Of note: there were no nursing notes on or around 12/27/19 that referenced physician or POAH contact related to change in dosing schedule for R1's [MEDICATION NAME]. On 8/4/20 at 10:00 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R1's hospice nurse wanted to make sure R1's pain was under control. DON-B stated, (R1's hospice nurse) stopped me in the hall and we discussed concerns that (R1) was not expressing pain but showing signs of pain so I said, 'Why don't we just schedule it (pain medication).' DON-B indicated hospice was responsible to obtain orders and notify family of changes for residents receiving hospice benefits. On 8/4/20 at 10:30 AM, Surveyor reviewed R1's [MEDICATION NAME] order in facility's Electronic Medical Record (EMR) system with DON-B. The [MEDICATION NAME] entry dated 12/27/19 stated, [MEDICATION NAME] HCl Tablet 5mg Give 1 tablet by mouth three times a day for pain. DON-B verified the nurse who entered this order on 12/27/19 was Unit Manager (UM)-F. On 8/4/20 at 10:35 AM, Surveyor interviewed UM-F who indicated UM-F could not recall the specifics of the order for R1's scheduled [MEDICATION NAME] on 12/27/19 except stated, (name of hospice company) used (physician name). It would have been the hospice nurse that obtained the order. When questioned about the facility's normal process for contacting physicians and processing MEDICATION ORDERS FOR [REDACTED]. UM-F stated, Sometimes they (hospice) fax the order directly to the pharmacy and we call the pharmacy to ask for a copy. Sometimes we get an order from our NP (Nurse Practitioner) because sometimes we are the ones to contact. Sometimes our NP in is the building so we can get it quickly. When questioned about who is responsible for contacting the family/POAH, UM-F indicated there would be a conversation between hospice and facility staff as to which would contact family/POAH. On 8/4/20 at 11:15 AM, DON-B informed Surveyor R1's medical record did not contain the original physician order [REDACTED]. we do it. On 8/4/20 at 1:15 PM, Surveyor reviewed with DON-B documents provided by facility to include an order for [REDACTED]. 27. 2019 3:50PM, was signed and dated by NP-H on 11/27/19, and stated, [MEDICATION NAME] 5mg 1 tab (tablet) po (by mouth) TID (three times a day) & (and) Q2hrs (every two hours) prn (as needed). DON-B verified the order for R1's scheduled [MEDICATION NAME] was obtained on 11/27/19 not 12/27/19. DON-B verified R1's November 2019 and December 2019 MARs indicated R1's scheduled [MEDICATION NAME] was not started until 12/27/19. DON-B verified not giving ordered medication doses constituted medication error. DON-B verified the expectation that R1's physician and POAH should have been updated regarding the medication error and R1's [MEDICATION NAME] dosing order should have been clarified with physician based on R1's condition status on 12/27/19. On 8/4/20 at 1:30 PM, Surveyor interviewed UM-F who indicated UM-F and R1's hospice nurse had discussed R1's pain management on 12/27/19 and stated, (Hospice nurse) brought it to my attention that it (the original [MEDICATION NAME] order from 11/27/19 was entered (into facility's EMR) incorrectly. UM-F verified the situation was considered a medication error. UM-F indicated the facility's usual process for addressing medication errors was to conduct an investigation, notify the physician and notify the family/POAH. UM-F verified this process was the responsibility of the facility, not the hospice. On 8/4/20 at 1:40 PM, Surveyor interviewed DON-B who verified the facility process for addressing medication errors was to conduct an investigation, notify the physician and notify the family/POAH. DON-B verified this process was the responsibility of the facility, not the hospice. On 8/4/20 at 2:15 PM, Surveyor interviewed DON-B. DON-B indicated being unaware of the medication error related to R1's scheduled [MEDICATION NAME] until 8/4/20 when alerted to situation by Surveyor. DON-B indicated the facility had no investigative documentation related to the medication error and was unable to locate clarification orders or any documentation that R1's physician or R1's POAH was notified of the medication error or [MEDICATION NAME] being scheduled on 12/27/19. On 8/4/20 at 3:25 PM, Surveyor interviewed NP-H via phone who indicated NP-H had not received notification of any medication error related to R1. When asked if the sudden increase in dosing of [MEDICATION NAME] could have hastened R1's death, NP-H stated, I wouldn't think so. 5mg TID is pretty small dosing.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and resident interview, the facility did not make a prompt effort to resolve two grievances for 1 Resident (R) (R2) of 1 residents. R2 filed two grievances with the facility regarding medication administration. The facility did not ensure a thorough investigation was initiated and a prompt and satisfactory resolution was reached. Findings include: The facility's Grievance Guideline policy, dated 1/27/17, statesd Residents have the right to voice complaints and make suggestions for change without the fear of reprisal, discrimination, coercion or unreasonable interruption of care, treatment and services. Grievances may be filed orally or in writing and may be anonymous if so desired. The facility will designate a Grievance Officer who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining confidentiality of all information associated with grievances; taking immediate action, as necessary, to prevent further potential violations of any resident right while the alleged violation is being investigated . The staff member will, at the time of the grievance, attempt to resolve the issue or direct the resident/representative to the appropriate department head or staff member for further action and/or notify the Grievance Officer. The Grievance Officer will route the grievance

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

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.

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) to the appropriate department head related to the grievance filed, and an investigation of the grievance will be conducted ; ensure action is taken to prevent further potential violations of any resident right while the alleged violation is being investigated . After thorough research has been conducted, the Department Head and/or Grievance Officer will work in [MEDICATION NAME] with staff identified as key individuals critical to problem resolution for the specific identified concern. All efforts will be made to effectively and expeditiously resolve the grievance. All grievances receive immediate priority and must be investigated with efforts made toward resolution within seven days. On 8/03/20, the Surveyor reviewed a complaint filed with the State Agency. The complaint stated R2 accused RN (Registered Nurse)-D of not administering R2's pain medication. The complaint also indicated RN-D signed out narcotics for multiple residents who stated they did not receive them. The Surveyor reviewed R2's medical record. R2 did not have an activated power of attorney and was admitted to the facility with [DIAGNOSES REDACTED]. R2's most recent Quarterly MDS (Minimum Data Set), dated 7/21/20, indicated R2 was cognitively intact, had scheduled and PRN (as needed) pain medication and took opioid medication for frequent pain. R2's MAR (medication administration record) contained an order for [REDACTED]. The Surveyor noted two grievances filed by R2. The first grievance, dated 6/16/20, stated R2 handed DON (Director of Nursing)-B a medicine cup containing two pills and stated they were given to (R2) on Saturday (6/13/20). R2 was concerned RN-D didn't administer R2's [MEDICATION NAME] as requested. R2 stated R2 slept all day and knew the two tablets in the medicine cup were not R2's. R2 stated R2 saw RN-D place a second medicine cup in RN-D's pocket. The investigation indicated DON-B confirmed where was more than one medication cup on the cart when RN-D prepared medication on 6/13/20. The investigation indicated the two pills in R2's cup were [MEDICATION NAME] (an anti-diarrheal medication) and [MEDICATION NAME] (a diuretic) neither of which were prescribed to R2. The investigation indicated RN-D prepared medication for more than one resident and mixed up the cups during the process. Interviews with three staff indicated R2 was awake in R2's wheelchair, laughing and joking with staff per usual throughout the weekend. The investigation also indicated RN-D was re-educated regarding medication preparation. The Surveyor noted the investigation did not contain interviews with residents to determine if other residents experienced or expressed the same concerns. The Surveyor noted the investigation did not contain interviews with staff regarding medication preparation and medication errors. In addition, the Surveyor noted staff education was conducted solely for RN-D. The second grievance, dated 6/18/20, stated R2 thought RN-D gave R2's meds while R2 was sleeping. R2 stated R2 did not wake up until 1:00 PM, was sweating, had a headache and didn't feel right. R2 was unsure whether or not the scenario happened or R2 dreamt it. The investigation indicated R2 was told if R2 didn't receive the correct medication, R2 could ask the nurse and request to see the medication cards. The investigation also stated, NHA (Nursing Home Administrator) requested (RN-D) not care for this resident. The follow-up section stated, Medication administration reviewed. Witness statements indicated (R2) awake during all medication passes. On 8/04/20 at 10:50 AM, the Surveyor interviewed UM (Unit Manager)-F who verified R2 was concerned R2 didn't receive the correct pain medication and indicated DON-B had the investigation. On 8/04/20 at 11:05 AM, the Surveyor interviewed DON-B who stated DON-B didn't receive any reports of drug diversion from residents or staff On 8/04/20 at 12:15 PM, the Surveyor interviewed R2 regarding both grievances. R2 stated RN-D administered the wrong medication to R2 on more than one occasion. R2 stated, I started taking pics of my pills. R2 also stated NHA-A entered R2's room a few weeks after the first grievance and indicating the facility was investigating R2's concerns, but couldn't provide more details. R2 stated R2 believed RN-D was diverting pain medication and reported the concern to NHA-A, DON-B and UM-F. R2 stated, I told (DON-B) I didn't want (RN-D) caring for me or doing my pills .and two days later, (RN-D) is giving me pills again. R2 stated DON-B said R2 couldn't pick and choose staff and can't dictate what nurses I can and can't have. R2 stated R2 requested RN-D be drug tested and wrote a letter to facility administration in mid-July that detailed her concerns. During the interview, RN-D knocked on R2's door and entered the room. RN-D asked if there was anything RN-D could do for R2. On 8/04/20 at 2:30 PM, the Surveyor again interviewed NHA-A and DON-B regarding the Surveyor's earlier conversation with R2. NHA-A and DON-B adamantly denied R2, or any resident or staff, reported an allegation of misappropriation of medication. DON-B verified a thorough investigation was not completed for R2's grievance dated 6/16/20. NHA-A verified R2's second grievance stated RN-D would not provide care for R2. NHA-A stated NHA-A was not aware RN-D still provided care for R2 and was not aware other options were not discussed, including a room change and the possibility of the second floor nurse administering R2's medication. DON-B verified RN-D still provided care and medication for R2 and stated it was not always feasible, based on the facility's census, to have two nurses on the first floor. On 8/04/20 at 2:50 PM, the Surveyor again interviewed UM-F who stated R2 did not inform UM-F of any drug diversion. UM-F stated (R2) did not say anyone took (R2's) meds or were diverting them. (R2) didn't ask that anyone be drug tested . UM-F verified RN-D still provided care and medication for R2. When asked if R2 was offered a room change or any options, UM-F stated, There are no rooms available upstairs. UM-F stated, I can tell staff to wait until I get in to administer (R2's) medication.
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** Based on staff interview and record review the facility did not provide pharmaceutical services to assure accurate administration of medications for 1 Resident (R) (R1) of 5 resident reviewed for medications. R1's physician had ordered scheduled pain medication on 11/27/19. On 12/27/19, it was identified that R1 had not received any of the scheduled doses as ordered. The facility administered the scheduled pain medication starting 12/27/19 without first clarifying the order with R1's physician based on R1's condition status on 12/27/19. Findings include: R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's medical record contained a Minimum Data Set (MDS) assessment dated [DATE] which stated R1's Brief Interview for Mental Status (BIMS) score was 99 which indicated R1 had severe cognitive impairment. R1's POAH document contained a Statement of Incapacity signed and dated 11/6/19 which indicated all R1's healthcare decisions were to be made by R1's designated POAH. R1 received Hospice benefits for pain management and end-of-life care. R1 passed away at the facility on 12/30/19. On 8/4/20, Surveyor reviewed R1's medical record which contained a Medication Administration Record [REDACTED]. The 12:00 PM dose on 12/30/19 was documented as held (not given) and the 4:00 PM dose on 12/30/19 was the last dose administered. Surveyor reviewed R1's medical record which contained nursing notes as follows: 12/30/19 at 11:31 AM - Per hospice nurse hold medication patient appears not in any pain and not responsive much at this time. 12/30/19 at 7:46 PM - Writer went to check if the resident was in pain. Writer found that the resident's vital signs had ceased. Writer called hospice and DON (Director of Nursing Services) to inform. Of note: there were no nursing notes on or around 12/27/19 that referenced physician or POAH contact related to change in dosing schedule for R1's [MEDICATION NAME]. On 8/4/20 at 10:00 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R1's hospice nurse wanted to make sure R1's pain was under control. DON-B stated, (R1's hospice nurse) stopped me in the hall and we discussed concerns that (R1) was not expressing pain but showing signs of pain so I said, 'Why don't we just schedule it (pain medication).' DON-B indicated hospice was responsible to obtain orders and notify family of changes for residents receiving hospice benefits. On 8/4/20 at 10:30 AM, Surveyor reviewed R1's [MEDICATION NAME] order in facility's Electronic Medical Record (EMR) system with DON-B. The [MEDICATION NAME] entry dated 12/27/19 stated, [MEDICATION NAME] HCl Tablet 5mg Give 1 tablet by mouth three times a day for pain. DON-B verified the nurse who entered this order on 12/27/19 was Unit Manager (UM)-F. On 8/4/20 at 10:35 AM, Surveyor interviewed UM-F who indicated UM-F could not recall the specifics of the order for R1's scheduled [MEDICATION NAME] on 12/27/19 except stated, (name of hospice company) used (physician name). It would have been the hospice RN that obtained the order. When questioned about the facility's normal process for contacting physicians and processing MEDICATION ORDERS FOR [REDACTED]. UM-F stated, Sometimes they (hospice) fax the order directly to the pharmacy and we call the pharmacy to ask for a copy. Sometimes we get an order from our NP (Nurse Practitioner) because sometimes we are the ones to contact. Sometimes our NP in is the building so we can get it quickly. On 8/4/20 at 11:15 AM, DON-B informed Surveyor R1's medical record did not contain the original physician order [REDACTED]. 27. 2019 3:50 PM, was signed and dated by NP-G on 11/27/19, and stated, [MEDICATION NAME] 5mg 1 tab (tablet) po (by mouth) TID (three times a day) & (and) Q2hrs (every two hours) prn (as needed). DON-B verified the order for R1's scheduled [MEDICATION NAME] was obtained on 11/27/19 not 12/27/19. DON-B verified R1's November 2019 and December 2019 MARs indicated R1's scheduled [MEDICATION NAME] was not started until 12/27/19. DON-B verified not giving ordered medication doses constituted medication error. DON-B verified the expectation that R1's physician and POAH should have been updated regarding the medication error and R1's [MEDICATION NAME] dosing order should have been clarified with physician based on R1's condition status on 12/27/19.

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) On 8/4/20 at 1:30P M, Surveyor interviewed UM-F who indicated UM-F and R1's hospice nurse had discussed R1's pain management on 12/27/19 and stated, (Hospice nurse) brought it to my attention that it (the original [MEDICATION NAME] order from 11/27/19) was entered (into facility's EMR) incorrectly. UM-F verified the situation was considered a medication error. UM-F indicated the facility's usual process for addressing medication errors was to conduct an investigation, notify the physician and notify the family/POAH. UM-F verified this process was the responsibility of the facility, not the hospice. On 8/4/20 at 1:40 PM, Surveyor interviewed DON-B who verified the facility process for addressing medication errors was to conduct an investigation, notify the physician and notify the family/POAH. DON-B verified this process was the responsibility of the facility, not the hospice. On 8/4/20 at 2:15 PM, Surveyor interviewed DON-B. DON-B indicated being unaware of the medication error related to R1's scheduled [MEDICATION NAME] until 8/4/20 when alerted to situation by Surveyor. DON-B indicated the facility had no investigative documentation related to the medication error and was unable to locate clarification orders or any documentation that R1's physician or R1's POAH was notified of the medication error or [MEDICATION NAME] being scheduled on 12/27/19. On 8/4/20 at 3:25 PM, Surveyor interviewed NP-G via phone who indicated NP-G had not received notification of any medication error related to R1 nor asked to clarify scheduled [MEDICATION NAME] order on 12/27/19 based on R1's status condition on that date. When asked if the sudden increase in dosing of [MEDICATION NAME] could have hastened R1's death, NP-G stated, I wouldn't think so. 5mg TID is pretty small dosing.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure 2 Residents (R) (R5 and R1) of 6 residents had medical records that contained complete and accurate documentation. R5 incurred a skin tear to the right elbow during a transfer on the 6/14/20 AM shift. R5's medical record did not contain documentation to indicate the skin tear was assessed or treated following its occurrence. In addition, R5's medical record did not contain documentation to indicate the skin tear was monitored. R1's physician had ordered scheduled pain medication on 11/27/19. R1's medical record did not contain this pain medication order. On 12/27/19, it was identified that R1 had not received any of the scheduled doses as ordered. In addition, R1's medical record did not contain documentation to indicate R1's physician and Power of Attorney for Healthcare (POAH) agent were not notified of this medication error. Findings include: 1. On 8/03/20, the Surveyor reviewed a complaint filed with the State Agency. The complaint stated R5's right elbow was injured during a sit-to-stand (mechanical lift) transfer on 6/14/20. The complaint stated the injury was reported to RN (Registered Nurse)-D; however, CNA (Certified Nursing Assistant)-C bandaged the wound when RN-D didn't respond. The complaint also stated the injury was not documented. On 8/03/20, the Surveyor reviewed R5's medical record. R5 was admitted to the facility with [DIAGNOSES REDACTED]. R5's ADL (activities of daily living)/Self Performance care plan stated R5 used a sit-to-stand lift for transfers. A progress note, written by RN-E and dated 6/15/20 at 3:41 AM, stated, Resident was found to have a skin tear to (right) elbow on 6/14/20 at approximately 6:45 PM when CNA was assisting resident with HS (bedtime) cares. Wound was cleaned and bandaged. A progress note, dated 6/15/20 at 1:35 PM, stated, (R5) bumped right elbow on door while using (sit-to-stand) transferring to the bathroom resulting in a skin tear. Area cleansed and [MEDICATION NAME] dressing (an absorbent dressing used to treat acute and chronic wounds) applied. NP (Nurse Practitioner) and family updated. A progress note, written by UM (Unit Manager)-F and dated 6/16/20 at 2:15 PM, stated, IDT (Interdisciplinary Team) met and reviewed in regards to having a skin tear to the right elbow. Staff will remind resident to keep elbows in while transferring. The Surveyor noted R5's medical record did not contain an assessment of the skin tear or documentation to indicate the skin tear was monitored. On 8/03/20 at 1:57 PM, the Surveyor interviewed RN-E regarding RN-E's progress note. RN-E was told the skin tear occurred at approximately 7:00 AM on 6/14/20 during the provision of AM cares. RN-E stated the injury was reported to RN-D by CNA-C. RN-E asked RN-D if the skin tear was assessed and treated. RN-E stated RN-D replied, That's my fault. I forgot about it. On 8/04/20 at 10:35 AM, the Surveyor interviewed RN-D regarding R5's skin tear. RN-D verified the injury occurred when CNA-C and an unknown aide transferred R5 to the bathroom. RN-D stated, They told me (R5's) elbow got bumped on the doorframe. I looked at the elbow, we cleaned it up and bandaged it . RN-D stated R5's elbow was a little skinned; however, RN-D couldn't recall the size or diameter of the tear and stated, I told the second shift nurse about it. It would be in PCC (Point Click Care) (the facility's medical record system) or a skin assessment. The Surveyor noted R5's medical record did not contain a skin assessment or documentation on 6/14/20 of R5's skin tear. On 8/04/20 at 10:50 AM, the Surveyor interviewed UM-F who stated staff were educated on sit-to-stand transfers following the incident. The Surveyor also noted staff were educated on assessments and DON (Director of Nursing) notification of all new injuries on 6/18/20. On 8/04/20 at 11:05 AM, the Surveyor interviewed DON-B regarding R5's skin tear. DON-B verified R5's medical record did not contain documentation to reflect the status of the skin tear and/or if the skin tear was monitored. On 8/05/20 at 11:41 AM, the Surveyor interviewed CNA-G who observed R5 in the bathroom on 6/14/20 and noted R5's right elbow was bleeding. CNA-G notified an unknown nurse who cleansed and bandaged the wound. CNA-G stated CNA-G did not assist with any of R5's transfers that shift and was on break prior to observing R5 in the bathroom around lunch time. As of this writing, CNA-C did not return two voice messages left by the Surveyor. 2. R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's medical record contained a Minimum Data Set (MDS) assessment dated [DATE] which stated R1's Brief Interview for Mental Status (BIMS) score was 99 which indicated R1 had severe cognitive impairment. R1's POAH document contained a Statement of Incapacity signed and dated 11/6/19 which indicated all R1's healthcare decisions were to be made by R1's designated POAH. R1 received Hospice benefits for pain management and end-of-life care. R1 passed away at the facility on 12/30/19. On 8/4/20, Surveyor reviewed R1's medical record which contained a Medication Administration Record [REDACTED]. The 12:00 PM dose on 12/30/19 was documented as held (not given) and the 4:00 PM dose on 12/30/19 was the last dose administered. 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DON-B indicated hospice was responsible to obtain orders and notify family of changes for residents receiving hospice benefits. On 8/4/20 at 10:30AM, Surveyor reviewed R1's [MEDICATION NAME] order in facility's Electronic Medical Record (EMR) system with DON-B. The [MEDICATION NAME] entry dated 12/27/19 stated, [MEDICATION NAME] HCl Tablet 5mg Give 1 tablet by mouth three times a day for pain. DON-B verified the nurse who entered this order on 12/27/19 was UM-F. On 8/4/20 at 10:35 AM, Surveyor interviewed UM-F who indicated UM-F could not recall the specifics of the order for R1's scheduled [MEDICATION NAME] on 12/27/19 except stated, (name of hospice company) used (physician name). It would have been the hospice nurse that obtained the order. When questioned about the facility's normal process for contacting physicians and processing MEDICATION ORDERS FOR [REDACTED]. UM-F stated, Sometimes they (hospice) fax the order directly to the pharmacy and we call the pharmacy to ask for a copy. Sometimes we get an order from our NP (Nurse Practitioner) because sometimes we are the ones to contact. Sometimes our NP in is the building so we can get it quickly. When questioned about who is responsible for contacting the family/POAH, UM-F indicated there would be a conversation between hospice and facility staff as to which would contact family/POAH. On 8/4/20 at 11:15 AM, DON-B informed Surveyor R1's medical record did not contain the original physician order [REDACTED]. we do it. On 8/4/20 at 1:15 PM, Surveyor reviewed with DON-B documents provided by facility to include an order for [REDACTED]. The document was titled Controlled Substance Prescription Form, had a fax time stamp date of Nov. 27. 2019 3:50 PM, was signed and dated by NP-G on 11/27/19, and stated, [MEDICATION NAME] 5mg 1 tab (tablet) po (by mouth) TID (three times a day) & (and) Q2hrs (every two hours) prn (as needed). DON-B verified the order for R1's scheduled [MEDICATION NAME] was obtained on 11/27/19 not 12/27/19. DON-B verified R1's November 2019 and December 2019 MARs indicated R1's scheduled [MEDICATION NAME] was not started until 12/27/19. DON-B verified not giving ordered medication doses constituted medication error. DON-B verified the expectation that R1's physician and POAH should have been updated regarding the medication error and R1's [MEDICATION NAME] dosing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525270	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROSSROADS CARE CENTER OF FOND DU LAC	**115 E ARNDT ST FOND DU LAC, WI 54935**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) order should have been clarified with physician based on R1's condition status on 12/27/19. On 8/4/20 at 1:30 PM, Surveyor interviewed UM-F who indicated UM-F and R1's hospice nurse had discussed R1's pain management on 12/27/19 and stated, (Hospice nurse) brought it to my attention that it (the original [MEDICATION NAME] order from 11/27/19) was entered (into facility's EMR) incorrectly. UM-F verified the situation was considered a medication error. UM-F indicated the facility's usual process for addressing medication errors was to conduct an investigation, notify the physician and notify the family/POAH. UM-F verified this process was the responsibility of the facility, not the hospice. On 8/4/20 at 1:40 PM, Surveyor interviewed DON-B who verified the facility process for addressing medication errors was to conduct an investigation, notify the physician and notify the family/POAH. DON-B verified this process was the responsibility of the facility, not the hospice. On 8/4/20 at 2:15 PM, Surveyor interviewed DON-B. DON-B indicated being unaware of the medication error related to R1's scheduled [MEDICATION NAME] until 8/4/20 when alerted to situation by Surveyor. DON-B indicated the facility had no investigative documentation related to the medication error and was unable to locate clarification orders or any documentation that R1's physician or R1's POAH was notified of the medication error or [MEDICATION NAME] being scheduled on 12/27/19.