STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

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)
E 0037 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish staff and initial training requirements.** Based on interview and document review, the facility failed to conduct initial Emergency Preparedness (EP) training for new employees. This had the potential to affect all 35 residents residing in the facility. Findings include: Interview on 8/20/20 at 10:55 a.m. with nursing assistant (NA)-G and licensed practical nurse (LPN)-B, identified NA-G began employment at the facility one month ago and was unaware if she had EP training. LPN-B was initially a contracted staff agency nurse who was subsequently hired by the facility and was unaware if she had EP training at the time of her facility employment. Interview on 8/20/20 at 11:49 a.m. with the assistant director of nursing (ADON) and payroll clerk (PC)-F, identified upon hire and annually thereafter, staff were required to complete online training modules which included EP. PC-F indicated there were specific modules new employees were supposed to complete before they started working on the floor, but no one had been making sure it was getting done. An undated, new hire list for 2020, identified of the 19 employees hired in 2020, only two, the director of nursing (DON) and (NA)-I had completed initial EP training upon hire. Interview on 8/20/20 at 2:10 p.m., the administrator identified he expected all new employees were to complete EP training upon hire. The facility no longer had a staff member who was responsible for oversight, as the human resource (HR) employee who had been responsible left employment in November 2019. The facility was in the process of hiring another HR person who would ensure the training was completed.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure call lights were in reach for 2 of 2 residents (R29 and R485). Findings included: R29's current, undated face sheet identified [DIAGNOSES REDACTED]. R29's current, undated careplan identified R29 required limited assistance of 1 staff for bed mobility, dressing, and toilet use. R29 was able to transfer himself from his bed to his chair independently and would peddle his self in the wheelchair. R29 has impaired safety awareness. Observation on 8/18/20 at 1:29 p.m., of R29's room identified R29's call light was laying on floor along the wall behind his bed and was not within reach. Observation and interview on 8/18/20 at 1:31 p.m., with registered nurse (RN)-A of R29's call light identified RN-A confirmed the call light cord was currently behind the bed laying on floor and out of reach of R29. RN-A identified the call light was to be kept within reaching distance of the resident. RN-A then placed call light on R29's bed within his reach. Further observation on 08/19/20 at 11:16 a.m., of R29's room identified his call light was hanging on the wall behind his bed and not within his reach. Interview on 8/19/20 at 11:17 a.m., with nurse aide (NA)-D identified she assisted R29 in laying down in bed earlier that day. NA-D voiced she had forgotten to ensure R29's call light was within reach. R485's current, undated face sheet identified [DIAGNOSES REDACTED]. R485's care plan included the resident is independent for transfers, bed mobility, and encourage the resident to use the call light for assistance. R485 had impaired safety awareness and severe mental cognition. Observation on 8/19/20 at 9:50 a.m., of R485 in his room identified R485 had recently been moved into the room. The room was equipped with a call light unit. Upon inspection, there was no cord attached to the unit. R485 was sitting in the recliner in the room with no call light within his reach. Interview on 08/19/20 at 1:18 p.m., with the director of nursing (DON) identified R485 would use his call light occasionally or was known to go directly to staff to ask for assistance. Her expectation was staff would have a working call light system in place prior to R485 moving into his new room. She would notify housekeeping to have a call light cord placed right away. She would expect all residents to have complete and functional call lights within reach. Review of the 7/25/16, Answering the Call Light policy identified staff were to ensure the call light was plugged in at all times. When a resident was in bed or confined to their chair, staff were to ensure the call light was within easy reach of the resident.
F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on observation, interview, and document review, the facility failed to ensure resident concerns identified at resident council meetings were addressed and residents notified of a resolution or ongoing measures to ensure compliance. This affected all 10 residents (R1, R3, R5, R8, R14, R16, R18, R20, R23, and R32) who attended resident council. Review of the 6/9/20, 7/9/20, and 8/13/20, Resident Council meeting minutes identified residents voiced concerns call lights were not always answered in a timely manner. There were no follow-up notes regarding any action to be taken by the facility or any resolution. Due to Covid-19 restrictions, the full resident council interview with surveyors did not occur. Interview on 8/18/20 at 10:15 a.m., with the activity coordinator (AC)-A identified R3 attended resident council meetings regularly, was cognitively intact and would be a good resident to interview for resident council. Interview on 8/19/20, at 8:00 a.m., with R3 identified grievances were not acted upon promptly by the facility and no resolution was ever offered. I went months without a call light. May, June, July and now August (2020). I told the nurses and I told activities coordinator (AC)-A during resident council meetings listed above, which they had attended. R3 stated she felt as though resident concerns were not being heard at council meetings and staff were not following up on concerns brought forth regarding the length of time it took for call lights to be answered. Interview on 8/19/20 at 2:01 p.m., with the director of nursing (DON) identified she was aware of resident concerns expressed at resident council meetings regarding call light response times. The facility was working on rearranging breaks on the second shift to address this issue. That information had not been shared with residents at a council meeting, but that it should have been in order for resident council to be aware of action taken to address their concerns. Interview on 8/19/20 at 2:15 p.m., with the administrator (A) identified he had not attended resident council meetings, but had read the meeting minutes. He had not noticed a pattern of concerns identified at council meetings. Comments are positive. When informed the minutes reflected concerns regarding call light response times for two months in a row, the A stated he was not confident staff watched the call light monitor at the nurses station because they were not always near it. The A was not certain they closely watched when resident room numbers that scrolled across the monitor at the end of the hallway. The A felt that was causing the long call light response times. The A's goal was for any call light response to be 10 minutes and stated he had shared that with the leadership team. He was not aware what the current call light response time was. The A was not aware of any specific action being taken to improve call light response times or if concerns regarding call light response raised by the resident council had been addressed. The A expected concerns raised by residents at council meetings to be acted upon and residents kept informed of action taken. The A felt this concern should be brought to the Quality Assurance Performance Improvement (QAPI) meeting with discussion to be had to work towards a resolution. Review of the April 2017 and 11/13/19, Resident Council policies identified the purpose of the resident council was to provide a forum for discussion of concerns and suggestions for improvement. The QAPI committee was

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

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F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) to review information and feedback from the resident council as part of their quality review. Questions and concerns raised at the meetings shall be noted in the minutes and a response from the appropriate department head shall be sought by the next meeting.
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 interview and document review, the facility failed to ensure the resident's representative was notified of a resident altercation for 1 of 4 residents (R2) reviewed for resident to resident abuse. Findings include: According to a facility reported incident, on 6/6/20, at 8:10 p.m., R2 yelled at another resident (R27) who was in his personal space. R2 struck R27 in the head several times and pushed her before staff could intervene. R2's quarterly minimum data set (MDS) assessment dated [DATE], indicated [DIAGNOSES REDACTED]. R2 had severe cognitive impairment with adequate hearing and vision, clear speech, was usually able to understand and be understood. R2 was independent in walking on the memory care unit. R2's plan of care dated 7/22/20, indicated he had the potential to be verbally and physically aggressive related to dementia. Interventions for this behavior included prompt response to signs and symptoms of irritability and frustration, redirecting residents who are in R2's personal space, or redirecting R2 when he seemed confused or at risk for doing something that may cause him distress. During a telephone interview on 8/17/20, at 3:53 p.m. R2's guardian (G)-C was unaware of any altercations between R2 and other residents. G-C stated the facility called him to inform him of things like medication changes or a missing hearing aid, but he had not been informed about an altercation between R2 and another resident. Facility incident report dated 6/6/20, described the resident to resident abuse between R2 and R27, and the individuals notified of the incident included the director of nursing and physician. R2's guardian who was also his emergency contact was not listed as being notified. During an interview on 8/18/20, at 2:17 p.m., nursing assistant (NA)-A stated she was aware of the altercation between R2 and R27 and stated R27 was everywhere on the unit and that made R2 angry sometimes. We reassure R2 that R27 likes to walk around and doesn't mean to get in his way. NA-A stated there was always staff in dining area of the memory care unit due to resident fall risk and altercation risk. During an interview on 8/18/20, at 2:30 p.m., (NA)-B stated she was aware of the incident between R2 and R27 that occurred in June and stated we make sure they keep their distance; we watch to make sure R27 is not in R2's space. During an interview on 8/19/20, at 12:09 p.m., assistant director of nursing (ADON) stated resident to resident abuse was reported to the physician of both residents involved, the family of both residents, the director of nursing (DON) and the administrator. ADON stated they would let a guardian know, whoever was the responsible party. ADON was not aware that R2's guardian had not been informed of the resident to resident abuse on 6/6/20. During an interview on 8/19/20, 2:01 p.m., the DON was unaware that R2's guardian was not notified of the resident to resident abuse that occurred on 6/6/20, stating I would expect staff to call the family just like they do for a fall. Stated she did not know off hand what the facility policy indicated, but stated R2's guardian should have been notified. Facility policy titled Abuse Prevention Program, dated 8/1/16, indicated: 1. Abuse can occur from resident to resident, staff to resident, family to resident or visitor to resident. 2. The reporting procedure included: a. The charge nurse had responsibility to conduct an initial investigation to ensure the investigation was timely and complete. b. The social services director, director of nursing or administrator would notify the resident's and/or the resident's representative of the investigation, keeping them informed of the progress of the investigation and informing them of the findings of the investigation and corrective action taken.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations and interview the facility failed to ensure rooms were maintained in a clean, sanitary, and homelike environment for 2 of 2 residents (R29 and R9). Findings include: Observation on 8/17/20 at 1:45 p.m., of R29's bathroom door had large scrapes and a gouge of wood missing on the outside and inside of the door. The shared toilet was running, the toilet paper roll was on the floor, and 2 large gray clumps of dust and debris were inside vent above the toilet. R29's closet doors had scrapes with wood missing and the floor heating vent had broken grates. The floor molding near the heating vent was loose and bulging out. Further observation of shared bathroom for R29 on 08/18/20 at 01:29 p.m., the toilet was still running, and the air vent above toilet remained heavily soiled dust. Interview on 8/18/20 at 1:35 p.m., nurse aide (NA)-B identified R29's toilet sometimes runs but if you wiggle the handle it will stop. NA-B had not reported the faulty handle to maintenance. Staff were to communicate maintenance needs in the maintenance book or directly verbally advise maintenance. NA-B identified if an environmental surface such as a floor, was in need of cleaning, it was the responsibility of housekeeping. During an observation of shared bathroom for R29 on 8/19/20 at 9:22 a.m., the vent remained dirty. During an observation on 08/20/20 at 9:11 a.m., R29's vent in bathroom remains dirty. During an observation on 8/17/20 at 1:55 p.m., of the shared bathroom for R9 identified a soiled bedpan with fecal matter visible inside was left lying on the bathroom floor. Further observation on 8/19/20 at 9:20 a.m., of R9's shared bathroom identified a soiled bedpan was hanging on a wall hook with fecal matter still visible inside. Interview on 08/19/20 09:25 a.m., with NA-C identified the bedpan in R9's bathroom was usually used by one of the residents however, NA-C was unaware which resident required a bedpan. NA-C had not used it to toilet R9. If staff use a bedpan, they were to wear gloves, use soapy water to clean, then rinse and wipe it down between uses for the day. NA-C confirmed the bedpan would not be considered clean, stated It is nasty. NA-C confirmed the usual facility process for after washing a bedpan without disinfection, was to store it in a closet until needed for use. NA-C was unaware which resident had used the bedpan. Interview on 8/19/20 at 9:32 a.m., with the DON confirmed the bedpan was dirty and had not been cleaned or disinfected. Staff were to clean bed pans after every use. Bed pans were only brought to the dirty utility room at end of day to be sanitized by night shift staff. DON asked NA-C to place bedpan in garbage bag and remove it from bathroom and take it to dirty utility room. The DON had not instructed NA-C to clean and disinfect the bedpan. Interview on 08/19/20 at 09:47 a.m., with housekeeping (H)-A identified staff are to report any damage in a residents room or notify maintenance of anything that required fixing or repair. Housekeeping routinely cleaned floors and vents, and were to notify maintenance if they were unable to clean something such as the floor vent or ceiling vent by notifying maintenance in writing in the Maintenance Request binder. During an interview on 08/19/20 at 1:39 p.m., with the Director of Nursing (DON) identified maintenance checked their maintenance book daily. If maintenance was required on the weekend or nights, staff were to call maintenance staff. During an interview and observation on 08/20/20 at 9:31 a.m., maintenance (M)-A identified he completes daily room checks including toilets and sinks. He surveys the facility twice a day and would check the maintenance request book daily. M-A worked Monday through Friday but was on call 24/7. Staff will put request in the maintenance book or they will also notify him in person if something is needed to be done immediately. Only written requests were documented in the maintenance book. M-A acknowledged the damaged grates in R29's room. He put bed guards on the beds that was known to break the vent grates. M-A would clean the floor vents yearly usually before winter and had not been made aware of any needing to be fixed. M-A agreed the damaged vents could be a safety issue. M-A would repair doors vs replace. M-A used a hardwood putty to repair damages to doors. M-A stated he was aware of damaged doors needing to be fixed and it is on his list to do as he points to his head. M-A identified housekeeping was also able to clean vents between preventative maintenance and yearly cleaning. M-A had no preventative maintenance cleaning schedule for overhead vents in the bathrooms but was aware and reported to have them on a to-do list. During an interview on 8/20/20 at 9:59 a.m., H-B identified housekeeping was to clean vents with a Swifter weekly. Housekeeping had no schedule or check-off list to ensure these had been done. There used to be a cleaning checklist but not all were completing it so it went away. H-B agreed the vents above R29's toilet were dirty and would clean it later that day. H-B identified the bathroom and closet doors being damaged and non-cleanable or homelike have been like that for nine years. During an interview and observation on 08/20/20 at 12:53 p.m., with the administrator (A) identified maintenance had a log book staff were to fill out for maintenance requests, however, staff will also directly notify him of needs so all requests are not documented. He is not aware of a maintenance schedule that maintenance follows. The facility just hired a head housekeeper to assist with items needed. The A was unaware of a housekeeping schedule either but expects a maintenance and housekeeping schedule to be planned and followed. The A identified housekeepers have their

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) daily routine but had no way to ensure all tasks had been completed. The A was new to the position and hoped to have improvements of expectations and set standards when each department's plans were formalized. Maintenance was playing catch up as previous maintenance director was let go a few weeks ago. The A stated R29's bathroom door and closet doors looked terrible and when he observed the edges. The doors should be maintained for appearance and safety. The A identified the broken and missing grates in the floor vents needed immediate repair. Maintenance needed to stay on top of those concerns and identify a plan to fix and make needed repairs throughout the facility. Record review of maintenance book did not include notification of R29's room maintenance needs. Review of 3/30/20, Cleaning and Disinfecting Resident Rooms policy identified housekeeping surfaces were to be cleaned on a regular basis, when spills occur, and when surfaces are visibly soiled. Environmental surfaces will be disinfected or cleaned on a regular basis and when surfaces are visibly soiled. There was no policy provided related to cleaning personal resident use equipment or the facility's preventative maintenance program.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to revise and update the care plan to include fall prevention interventions for 2 of 3 residents (R1 and R19) reviewed for accidents. Findings include: R19's current [DIAGNOSES REDACTED]. R19's quarterly Minimum Data Set assessment dated [DATE], documented R19 scored three on her brief interview for mental status, indicating severe cogitation deficit. Further, R19 requires extensive assistance with all activities of daily living, total dependence with toileting, able to stand with assistance only and unable to walk any distance. R19's care plan, last updated 7/26/20, indicated R19 had cognitive impairments, forgetfulness, self-care performance deficit related to dementia, limited physical mobility, history of elopement attempts, impaired communication, fall risk due to dementia, and actual falls related to poor balance. R19's Resident Fall Risk assessments dated 9/9/19 to 7/22/20, indicated R19 has intermittent confusion, three or more falls in the past three months, requires an assistive device for mobility, balance problems while standing and walking, and decreased muscular coordination. R19's fall incident reports documented ten falls from 9/3/19 to 7/26/20: Fall #1 on 9/3/19, at 7:25 a.m. documented R19 was found sitting on the floor in her room. No injuries were noted. The incident report was completed, however, the care plan was not updated. Fall #2 on 9/16/19, at 9:35 a.m. documented R19 was observed sitting with both knees on the foot rest of her wheelchair. No injuries were noted. The incident report was completed, however, the care plan was not updated. Fall #3 on 10/21/19, at 2:15 p.m. documented R19 was observed sitting on the floor next to her bed. No injuries were noted. The incident report was completed, however, the care plan was not updated. Fall #4 on 11/24/19, at 7:48 a.m. documented R19 was observed sitting on the floor next to her bed. No injuries were noted. The incident report was completed, however, the care plan was not updated. Fall #5 on 12/10/19, at 4:13 p.m. documented R19 was observed on the floor of her room. No injuries were noted. The incident report was completed, however, the care plan was not updated. Fall #6 on 1/2/20, at 8:00 a.m. documented R19 was observed lying on the floor in her room. No injuries were noted. The incident report was completed, however, the care plan was not updated. Fall #7 on 1/21/20, at 7:55 p.m. documented R19 was observed lying on the floor in the middle of her room. R19 complained of head, ear and shoulder pain. The incident report was completed, however, the care plan was not updated. Fall #8 on 4/10/20, at 7:50 p.m. documented R19 was observed lying on the floor next to her bed. No injuries were noted. The incident report was completed, however, the care plan was not updated. Fall #9 on 7/20/20, at 8:45 p.m. documented R19 was observed lying on the floor next to her bed. No injuries were noted. The incident report was completed, however, the care plan was not updated. Fall #10 on 7/26/20, at 6:20 p.m. documented R19 was observed lying on the floor next to her bed. No injuries were noted. The incident report was completed and the care plan was updated with staff will anticipate R19's needs and ensure her items are within reach. During an interview on 8/19/20, at 1:38 p.m. the director of nursing (DON) stated the interdisciplinary team reviews all falls and there should be an updated care plan for each fall. During an interview on 8/20/20, at 10:33 a.m. DON stated we are missing updating fall prevention interventions in the care plan. The faciity started a falls focus group that met for the first time on 8/10/20 and the focus group will complete the root cause analysis of each fall and create new fall prevention interventions. During an interview on 8/20/20, at 9:52 a.m. nursing assistant (NA)-A stated we get updates in the care plan for new fall prevention interventions. NA-A further stated, that's how I know of new fall prevention interventions. During an interview on 8/20/20, at 10:08 a.m. licensed practical nurse (LPN)-A displayed the care plan in PointClickCare electronic medical record. She indicated all staff have access to the care plan, however, she was unable to display fall prevention interventions. LPN-A further indicated there are papers in the nursing station with the plan of care. Upon investigation, LPN-A could not find the care plan papers. The facility's, Goals and Objectives, Care Plans, policy last reviewed 10/19/19, directed staff to enter goals and objectives in the residents care plan that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. The facility's, Care Plans - Comprehensive, policy last reviewed 10/17/19, directed staff to develop and maintain a comprehensive care plan that is ongoing and revised to meet the desired outcome. The facility's, Falls and Fall Risk, Managing, policy last reviewed 3/13/20, directed staff to identify appropriate interventions to reduce the risk of falls. R1 Interview with R1 on 8/17/20 at 3:29 p.m., identified she had fallen out of bed and broke her nose approximately month ago. R1's 7/21/20, quarterly Minimum Data Assessment (MDS) identified R1 had moderately impaired cognition. R1 required extensive assistance with bed mobility. She used a walker and was able to walk in her room and use the toilet independently. She required supervision of a staff member to walk in the hallway. R1 had frequent pain. She rated 8/10 treated with medication and non-pharmalogical interventions. R1 had a history of [REDACTED]. R1's 8/19/20, [DIAGNOSES REDACTED]. R1's 8/17/20, care plan identified R1 had self care deficits. R1 used a four-wheeled walker to use the toilet and walked in her room independently. R1 required extensive assistance of 1 staff for bed mobility. R1 required assistance of 1 staff to manage incontinence. R1 resisted cares and was susceptible to falls when agitated. R1 had actual falls with minor injury, poor balance, unsteady gait, and confusion. Staff were to monitor, document, and report symptoms of bruises pain, change in mental status, inability to maintain posture and agitation. Staff provided activities to promote exercise and strength building when possible, R1 had chronic pain and [MEDICAL CONDITIONS]. R1's was pain relieved with rest, and pain medication. Staff were to anticipate R1's needs, and respond immediately to any complaint of pain. R1 was able to call for assistance when in pain, reposition self, ask for medication, and verbalize what relieved her pain. R1's Risk Management reports identified the R1's fall history included the following: 1) On 11/9/19 at 4:30 p.m., R1 had and unwitnessed fall with no injuries. R1 was found seated on the floor in front of her room in the hallway. R1 lost her balance trying to tie her shoe. The report made no mention R1's R1's fall care plan was reviewed and no interventions were included in the report. 2) On 11/17/19 at 6:00 p.m., R1 had an unwitnessed fall. R1 was found lying on her stomach on the floor. R1 was bleeding from her mouth and an open area on her nose. R1's estimated blood loss was 200 to 300 milliliters (ml). R1 was crying and had facial pain rated 6/10 pain throughout her face. R1 was sent to the emergency department (ED) for an evaluation. R1 reported she was getting her walker and became entangled in it. The report made no mention R1's fall care plan was reviewed and no interventions were included in the report. 3) On 5/2/20, at 3:08 p.m. R1 had an unwitnessed fall. R1 was found on the floor in front of her recliner. R1 had sat on the edge of the recliner and slid to the floor. R1 had no injuries. The report made no mention R1's fall care plan was reviewed and no interventions were included on the report. 4) On 5/18/20 at 9:00 a.m., R1 slipped out of her recliner during breakfast. After breakfast, R1 attempted to get her shoes out of the back of her closet fell forward, and landed on her bottom. R1 had no injuries. The report made no mention R1's fall care plan was reviewed and no interventions were included in the report. 5) On 7/15/20, R1 had an unwitnessed fall. R1 had no injuries. R1 was found on the floor in the hallway outside her room. R1 became dizzy and fell . The report made no mention R1's fall care plan was reviewed and no care plan interventions were included in the report. R1's Fall Risk Assessments were completed on 1/18/20, 4/18/20, and 7/18/20. The assessments made no mention R1's fall care plan was reviewed and no interventions were included on the report. R1's nurse notes identified the following: On 11/14/20, the interdisciplinary team (IDT) reviewed R1's 11/9/19 fall was reviewed R1 was independent in the building with a front-wheeled walker. R1 was safety aware and had no injuries. R1 was reassured staff were to assist her when her shoes come untied. The note made no mention R1's care plan was updated. On 11/17/20, R1 was evaluated in the ED. R1 had a closed

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) [MEDICAL CONDITION] bone. R1 had bruising around her eyes, nose, and on both knees. R1 had a swollen nose and lips. R1 was ordered tylenol and ice for pain relief. R1's call light was within reach, and she was told not to get out of bed without assistance tonight. On 11/18/20, R1's bruising to her right eye extended to her right eyelid, and her eye was swollen shut. R1 continued to have slow oozing blood from her left nare. R1's nare was packed with gauze. On 11/18/20, R1 had an appointment with her physician . R1's aspirin and Xarelto were held, for three days, [MEDICATION NAME] spray was ordered three times daily for 3 days, and she was to receive ice packs as needed. On 11/21/2019, the IDT reviewed R1's fall on 11/17/19. R1 was able to retain her safety needs and was independent with a front-wheeled walker in the facility. R1 was reminded to notify staff with concerns and needs. Staff were to continue to provide assistance as needed. On 1/21/20 at 2:51 p.m. R1 was sitting on her floor between her bed and bathroom. R1 had lost her remote and she decided to sit on the floor. R1 had no injury. No Risk Management report was associated with this event. On 1/22/20, R1 complained of pain in her upper arm and right shoulder. R1 had pain with movement. R1's physician was faxed and an x-ray ordered. R1 was given pain medication. Staff were to continue to monitor. A report on 1/24/20 identified no fractures were present in R1's right arm. On 5/18/20 at 9:00 a.m., R1 slid out of her recliner onto the floor. Then after breakfast, R1 got out of her recliner to get her shoes from the back of her closet. R1 fell forward, then onto her bottom. R1 had no injuries. No additional interventions or review of her fall were included her nurse notes. On 7/15/20 at 4:00 a.m., R1 was found on the floor in the hallway outside her room. R1 had blood on her tongue and lips. R1 had bit her tongue. No immediate interventions were documented to prevent falls were included in the notes. On 7/1/2020, during physician rounds R1 was received orders for occupational (OT) and physical (PT) therapy evaluation and treatment. On 7/15/2020 at 4:00 a.m., R1 was found by a nursing assistant (NA) lying on the floor in the hallway outside of her room. Resident stated she didn't know what she was doing, became dizzy, fell , and bumped her head. R1 had blood on her tongue and lips. R1 had a 6 centimeter (cm) by 5 cm purple bruise on her chin. R1's right arm was swollen and had a 10 centimeter (cm) by 10 cm purple bruise. R1's left elbow had a 4 cm by 3 cm purple bruise. R1's right knee was swollen and had a 9 cm by 9 cm reddish/purple bruise, and her left knee had a 4 cm by 6 cm bruise. R1's left breast had a 7.5 cm by 6 cm purple bruise. At 7:45 a.m., R1 was found to have swelling and bruising on her right biceps and right knee from her fall earlier in the morning. An ice pack was used for swelling. There was no mention of any immediate interventions put in place to prevent falls. On 7/20/2020, the IDT team reviewed R1's 7/15/20 fall. The note identified R1 was evaluated in the ED on 7/18/20. R1 had no injuries. R1 complained of pain, and returned to the facility with and order for [MEDICATION NAME]. R1 was reminded to use her call light and staff were to continue to anticipate her needs. No additional immediate interventions were included in the note to prevent further falls. Observation of R1 on 8/19/20, between 8:00 a.m. and 8:24 a.m. identified R1 was lying on her bed positioned with her head at the footboard with her torso and hips on the bed. R1's lower extremities dangled of the side of the bed a blanket on the floor wrapped around her ankles. R1's eyes were closed. The activities director entered the room and asked R1's roommate what she wanted for breakfast and exited the room. Nursing assistant (NA)-H peered into the room looked at R1, and exited the room without assisting R1 into bed. Housekeeper (H)-A, who was also a nursing assistant, entered the room and positioned R1 into bed. Interview on 8/19/20 at 8:30 a.m., with H-A identified she was also a certified nursing assistant. She worked only as a housekeeper at the facility, but also assisted residents with meals and occasionally with toileting if needed. She was familiar with R1's care. R1 usually slept in in the morning and was fed breakfast when she woke up. R1 had no recent falls to her knowledge. Staff followed the resident's care plans. She was unsure of R1's fall history or how fall interventions were communicated between staff because she worked in housekeeping. If she had questions, she asked the NA's and nurses. Observation of R1 on 8/19/20 at 2:21 p.m., identified R1 with her walker ambulating in the hallway without assistance. She ambulated from her room across the hallway. Unidentified staff were working in the hallway and did not assist R1 while out of her room. R1 walked to the to the opposite wall across from her room, turned and walked back to her room. No staff approached R1 to offer ambulation or assistance. R1 returned to her recliner. Observation of R1 on 8/20/20 at 8:45 a.m. and 9:30 a.m. identified R2 was in bed. An unidentified staff entered the room and assisted R1 to sit in her recliner. R1's door was open and she sat upright with her head tilted back and her mouth wide open and eyes closed. Her breakfast tray sat in front of her, covered with a lid. Staff were in the hallway passing meal trays and assisting other residents with their breakfasts. Interview on 08/20/20 at 10:43 a.m., with licensed practical nurse (LPN)-C identified R1 rarely missed breakfast. R1 was put into her recliner that morning to encourage her to eat because her blood sugar was low. R1 sat in her room and not in the main dining room because she required supervision to eat. A few weeks ago R1 started missing breakfast because she was sleeping in later. R1 had some [MEDICAL CONDITION] that was thought to be caused by her room mates tendency to stay up late at night. R1 used to go the dining room to eat until COVID restrictions were implemented, but she was sleepier in the dining room and staff decided to feed her in her room. Staff were to let her sleep in and serve her meal when she wakes up. The director of nursing (DON) and the assistant director of nursing (ADON) were responsible for updating care plans after falls and when needed. Floor nurses only completed risk management documentation when a resident fell , and IDT determined interventions for fall prevention during their meetings. LPN-C was unsure if any new fall prevention interventions were in place for R1. Interview on 8/20/20, at 11:53 a.m., with the DON identified residents were assessed for falls quarterly. R1's care plan was not reviewed after every fall, and immediate interventions were supposed to be implemented by the charge nurse. R1 had falls from her recliner and her recliner was not assessed for safety when she fell . Any interventions the facility implemented should be included in the care plan and communicated to staff. The DON stated fall analysis was not being reviewed to ensure care plans were appropriate, and updated with current interventions. A fall committee was initiated as a quality assurance and performance improvement (QAPI) project, however no meetings have been started. Staff were still learning how to use their documentation program. The 3/13/20, Falls and Fall Risk, Managing policy identified the purpose of the policy was to identify interventions related to resident specific fall risks to try to prevent residents from falling and to try to minimize complications from falling. All staff with the input of the attending physician were to identify appropriate interventions to reduce the risk of falls. If falling occurred despite initial interventions, staff were to implement additional or different interventions or indicate why the current approach remained relevant. In conjunction with the attending physician, staff were to identify and implement relevant interventions to try to minimize serious consequences of falling. Staff were to monitor and document each resident's response to interventions intended to reduce falling or risks of falling. If a resident continued to fall, staff were to re-evaluate whether it is appropriate to continue or change current interventions. The staff and/or physician was to document the basis for conclusions that specific irreversible risk factors existed that continued to present a risk of falling or injury due to falls.
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 observation, interview, and record review, the facility failed to ensure staff followed professional standards of practice with medication administration for 2 of 8 residents (R5 and R6) observed during medication administration pass. Findings included: R6's admission record included [DIAGNOSES REDACTED]. R6's quarterly Minimum Data Set (MDS) 5/21/20 indicated intact cognition. During an observation on 08/19/20 at 7:45 a.m., R6 who was seated in her wheelchair near nurse station and medication cart. Licensed practical nurse (LPN)-A was observed to give R6 medications in a medication cup with a diet coke. LPN-A turned away from resident before observing resident taking medications and walked into another resident room prior to finishing her medication administration. Review of R6's self administration of medication assessment dated [DATE] and 5/18/20 identified staff marked No/unable to determine and continue with current plan of care. R5's quarterly MDS dated [DATE] identified cognitive function with a BIMS of 2, severe cognitive impairment and usually understands direction. R5's admission record included [DIAGNOSES REDACTED]. During an observation of medication administration 8/19/20 at 8:05 a.m. for R5, LPN-A administered inhaler to R5 and did not provide a mouth rinse following as directed on order. LPN-A did not ask resident if they wanted to do a mouth rinse and administered the next inhaler along with oral medications. LPN-A confirmed she did not ask and stated she was under the impression R5 does not want to do mouth rinses. Record review of R5's medication orders indicate [MEDICATION NAME]-[MEDICATION NAME] Aerosol 160-4.5 mcg/ACT 2 puffs inhale orally two times a day for [MEDICAL CONDITION]/[MEDICAL CONDITION]. Shake well before use. Rinse mouth after use. During an interview on 8/19/20 at 1:15 p.m., director of nursing (DON) stated there would be an order for [REDACTED]. Record review of Administering Medications Policy last reviewed on 11/6/19 included the following: medications must be administered in

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	245395	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) accordance with the orders, including any required time frame; staff shall follow established facility infection control procedures for administration of medications; 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.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure staff used appropriate hand hygiene and glove use during meal service, and housekeeping duties. This had the potential to affect 6 of 6 residents (R5, R6, R12, R13, R23, and R31) assisted during meals, and 23 of 35 residents with rooms located in the South-wing of the facility. Findings include DINING Observation on 8/17/20 at 5:47 p.m., identified R5, R6, R12, R13, R23, and R31 were seated in the South Wing lounge for meals. Nursing assistant (NA)-C was in the dining area and assisted resident (R)31 and R13 to don clothing protectors. R31 was drooling and had drool on his hands NA-A touched R31 hands while applying his clothing protector. NA-C approached R12 and assisted R12 to don a clothing protector. NA-C also touched R12's face, wheelchair handles, and tray table. NA-C assisted R6 with tying her clothing protector and also touched R6's tray table. At no time had NA-A or NA-C performed hand hygiene before, during or after contact with the above mentioned residents. Observation on 8/17/20 at 5:55 p.m., identified NA-C observed drool on R31's face. Without performing hand hygiene, and donning gloves, NA-C used a Kleenex to wipe R31's face, and discarded the Kleenex in the trash. NA-C then removed a glass from R6's table and returned to R31 to assist him to eat. NA-C fed R31 with a few bites then stood up and walked to R12 to assist her to eat. NA-C touched R12's wheelchair handles, silverware, and drinking glasses. When finished assisting R12, NA-C used the clothing protector to wipe R12's face and left the table. R13 was eating independently and had difficulty scooping mashed potatoes out of a bowl. NA-C touched the spoon R13 was using to scrape the potatoes into the center of the bowl, and handed R13 the spoon. R13 grabbed the spoon and resumed eating. NA-C approached R12 to attempt to feed her. R12 did not eat. NA-C wiped R12's face with the clothing protector. NA-A returned to R13's table and assisted her to finish eating her mashed potatoes and meat. At no time had NA-A or NA-C performed hand hygiene before, during or after numerous contact with the above mentioned residents. Interview on 8/17/20 at 6:25 p.m. with NA-A identified staff would only wash their hands between residents if food was directly touched. NA-A identified she make no direct contact with resident's food while assisting the residents to eat, and had used a tissue to wipe R31's face. ENVIRONMENTAL CLEANING Observation on 8/18/20 at 8:42 a.m., of housekeeper (H)-A identified H-A exited R8 and R12's room wearing gloves. The new housekeeping manager was present observing the cleaning process. Without removing gloves and performing hand hygiene, H-A entered room R5 and R12's room. H-A grabbed clean wash rags and brought them into the room and wiped high touch surfaces. H-A exited R5 and R12's room placed the soiled rags in a dirty rag bin. H-A grabbed the mop handle and a cleaned the mop head. After mopping, H-A removed the soiled mop head. H-A wiped the TV, clock, side table, and door handles. H-A wiped the bathroom sink and emptied the trash. H-A pushed the housekeeping cart to R11's room. H-A reached in to the clean rag bin filled with cleaning solution, grabbed a clean rag, entered the room and wiped down high touch surfaces, mopped the floor and removed the soiled mop head and exited the room. At no time had H-A performed hand hygiene before, during or after numerous contact with the above mentioned residents environmental surfaces. Interview on 8/18/20 at 9:09 a.m., with H-A identified she was unsure of the dry times for the cleaning supplies. Gloves were to be changed and hand hygiene performed if she was going to assist residents with meals, or after handling trash. Changing gloves was not necessary between rooms because they were sanitized when they were in contact with the cleaning solution the rags and mop heads were contained in. Interview on 8/18/20 at 9:20 a.m., with the new housekeeping manager (HM) identified it was her first week working at the facility. She was unfamiliar with the facility's room cleaning policies and procedures. HM was observing the housekeepers to familiarize herself with the facilities housekeeping practices. She had worked in housekeeping services for many years and was familiar with housekeeping practices in other settings. HM verified staff were using single use blue [MEDICATION NAME] gloves while cleaning resident rooms. They were to be removed and hand hygiene performed before and after cleaning resident bathrooms, between resident rooms, after emptying trash, and after handling soiled rags and mops. Interview on 8/20/20 at 12:21 p.m. with the assistant director of nursing (ADON) and infection preventionist, identified staff were trained on appropriate hand hygiene and glove use. Staff were expected to wash hand after providing direct cares, before and after removing gloves, in between cleaning rooms, and before and after clean to dirty practices. Staff were to wash hand after handling bodily fluids, and before and after direct cares, and between assisting residents with meals and before and after glove use. Review of the 10/29/19, Handwashing/Hand Hygiene policy identified staff were to follow hand hygiene procedures to prevent the spread of infections to other personnel, residents, guests, and visitors. Staff were required to perform hand hygiene included before and after assisting residents with meals, when hands were visibly soiled, after contact with a resident, before and after direct contact with resident's bodily fluids, after contact with a resident's intact skin, after contact with objects in immediate vicinity of the resident, before moving from a contaminated body sit to a clean body site during resident care, and before and after removing gloves. Review of the 3/30/20, Cleaning and Disinfecting Residents' Rooms policy identified staff were to perform hand hygiene after removing gloves. Staff were to use heavy-duty gloves and other personal protective equipment (PPE) as indicated for housekeeping tasks. Heavy-duty gloves could be reused as long as the integrity of the gloves was intact and long as they were disinfected regularly. The policy made no mention of the frequency single-use gloves were to be changed during the housekeeping process. MEDICATION ADMINISTRATION During an observation of the morning medication passes on 08/19/20 at 7:45 a.m. and at 8:05 a.m. LPN-A did not perform hand hygiene before and after medication pass of two separate unidentified residents. During an observation on 8/19/20 at 8:16 a.m., LPN-A was observed to touch her medication cart with out washing her hands or the surfaces after items were placed and removed from her cart top and side table. LPN-A again did not perform hand hygiene prior to setting up medications. LPN-A put on gloves prior to obtaining a blood glucose check but did not perform hand hygiene after removing gloves or prior to administering oral medications to same resident. During an interview on 8/19/20 at 8:28 a.m., prior to LPN-A starting another medication pass, surveyor intervened and asked LPN-A when hand hygiene should be performed. LPN-A stated hand sanitizer should be applied after every med pass and every resident and after glove removal. LPN-A stated she did not remember if she performed hand hygiene. During an interview on 8/19/20 at 1:15 p.m., the DON stated hand hygiene was expected after glove use and in between resident medication administrations. Record review of Handwashing/Hand Hygiene Policy updated on 10/29/19 included the following: all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; use alcohol hand rub before and after direct contact with residents, before preparing or handling medications, after contact with medical equipment in the immediate vicinity of resident, and after removing gloves.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 3 of 3 residents (R3, R19, and R25) call light system was functioning properly or maintainenced by the manufacturer when continued concerns were not resolved. This had the potential to affect 35 of 35 residents in the facility. Findings include: Interview on 8/17/20 at 3:46 p.m. with R3 identified her call light had not worked for 4 months. R3 stated she had told staff several times and also had asked the managers of the facility when they were going to fix her call light at her most recent care conference. R3 identified when she pushed the call light button, the light did not always show up on the box. Sometimes it would stay on, and no one would answer her light when it was activated. R3 activated her call light. The banner in the hallway did not identify R3's call light was activated. Nursing assistant (NA)-E answered the light. He stated it was showing as activated on the monitor at the nurse desk. Nursing staff would not be able to see if it was on if no one manned the desk. NA-E stated he would inform the charge nurse R3's call light was not working. NA-E walked to the nurse station. Additional observations of the call light system on 8/17/20 identified the following: 1) At 4:00 p.m. R25 's call light was activated at 4:03 p.m. the light was deactivated. At 5:11 p.m. R25's call light was rolling across the banner in the hallway. The light remained on until the survey team exited the floor at 7:00 p.m. 2) At 4:00 p.m., R25's call light was observed on the screen. R25 was in the room writing a letter. She identified she had not activated her call light. R25 had a single room.

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F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) The call light unit's light was off, indicating it was not activated. At 5:11 p.m. R25's call light continued to be on the banner in the hallway and remained on until 7:00 p.m. 3) At 4:00 p.m., room [ROOM NUMBER]'s call light was activated. The room was empty and unoccupied. 4) At 7:30 p.m. R3's call light was activated and did not show up on the nurse station monitor or the banner in the hallway. R3 stated that is what happened every time her call light stopped functioning. It would not activate properly or stop working altogether. At 7:30 p.m. The administrator was notified the call light in R3's room was not functioning properly. Observation of call lights on 8/18/20 identified 1) At 8:12 AM R25's call light was rolling across the banner in the hallway R25 was not in her room. 2) At 08:12 a.m. R19's call light was on the screen and flickered off and on intermittently , but continued to roll across the banner. 3) At 8:25 a.m. R25's call light remained on in the hallway. R25 was in her room and identified she had no put her call light on. The red light on her call light box was off. 4) At 9:32 a.m. R25's call light continued to show on the banner in the hallway. R25 was not in the room, and the red light on the call light box was not on. 5) At 1:26 p.m., R25's room light continued to be on. R25 was not in her room. Interview on 8/18/20 at 1:28 p.m. with NA-B identified R25's call light had been on since 11:09 a.m., about 2 hours. NA-B stated the call light batteries sometimes die and don't know when they are replaced. When a light doesn't work properly nursing assistants either notify maintenance or change the batteries. NA-B identified there was no process in place to routinely check call light functioning. Batteries runs out once or twice per month, and staff do not routinely check or replace the batteries. NA-B had not noticed R25's light had been on for two hours, and went to check R25's room to ensure she had not missed lunch. NA-B replaced R25's call light battery. The light continued to be on. NA-B identified R25's call light had a phantom light that was always on. A call light box must was misplaced or maintenance had placed it somewhere and it had not been deactivated. NA-B was unsure how long this light had been like that. When resident call lights were not working, staff attempted to stop by the rooms frequently to see if they needed assistance. Interview on 8/18/20 at 1:39 p.m., with NA-D identified the health information (HIM) manager was responsible for reprogramming call lights. The HIM manger worked between this facility and its sister facility across town. When the call light boxes needed replacing, maintenance requests were recorded on the maintenance log. Sometimes staff swapped call light units with one from an empty room when they were not working. The call light units were assigned to specific rooms, so staff had to keep track of which room light was borrowed to ensure they answered the call light for the resident using it because the room number on the screen was not always the same number as the resident using the call light. Staff reported to each other which resident was using which light until the call light was reprogrammed or replaced. R25's call light was one maintenance replaced, but it keeps triggering the call light system. Observation of R3's call light on 8/19/20, identified the call light was not activated in her room, but was active on the banner in the hallway. R3 was in the main dining room on the lower level eating breakfast. Review of the Maintenance log on 8/18/20 at 2:20 p.m., identified R3's light was repaired. Observation on 8/18/20 at 2:40 p.m., of R3' call light identified the light was turned off. R3 activated the call light, The light was activated in R3's room and did not display on the banner in the hallway for 2 attempts. Interview on 8/18/20 at 3:07 p.m., with the administrator (A) identified the call light system was not great. He would expect the lights to be working correctly if the maintenance log was initialed and noted as fixed. The maintenance man was responsive and fixed things promptly. Several call light boxes were recently replaced. NA's were expected to report when call lights were not working and were to record lights not working on the maintenance log at the nurse station. For immediate needs staff were expected to talk to maintenance. The facility had purchased bells a while ago to distribute to residents in case the call light system was not working. The bells had not yet been distributed to residents. The administrator was shown R3 and R25's call lights and confirmed they were not functioning properly. A call was made to the eminence manager to returned to the facility to fix the call lights. An interview on 8/18/20 at 3:30 p.m. with the maintenance manager identified sometimes the power to the call light system gets unplugged. The system was located at the locked unit nurse desk. the unit was plugged in under the nurse desk and was functional. The HIM worked part time at the facility and was able to reset the system when it was not functioning properly. She was off of worked due to illness. No one else was trained to reboot the call light system. He agreed the facility should have other another staff member trained to be able to reboot the system. if the system becomes overloaded, it malfunctioned and needed to be rebooted. He was unsure if the company had been contacted to perform a eminence check on the system. The call light system had problems for the past year, and the problem was ongoing. In past when the call lights were not working, the HIM was called to reprogram the system. He thought the assistant director of nursing (ADON) may know how to reprogram the call light system, but was unsure. There was no indication the manufacturer had been contacted to service the call light system to ensure it was in working order. An interview on 8/18/20 at 3:51 p.m., with the ADON identified she was not trained on how to program call light system. The ADON thought the HIM and potentially the activity director knew how. Interview on 8/18/20 at 3:50 p.m., with the activity director identified she did not know how to reset call lights but she was on the phone with the HIM to try to fix the call lights. She only knew how to reset a call light to a resident's room. She stated she had already fixed room R19's call light. She was provided a list of resident's call lights who were currently not working. An interview on 8/19/20 at 11:11 a.m., with the ADON identified whenever management or maintenance gets a report from any staff of more than one call light not working, all call lights were checked for proper function. When the call-light system was reset, every all light was checked. The audits were not documented. An interview on 8/19/20 at 2:00 p.m. with the administrator identified he was not sure if there a call light log was maintained by the manufacturer or when the call light system had to last be reset. The activity director or HIM were responsible for resetting the system. The activity director just learned how to reset the the call lights yesterday. Each call light was programmed for a specific room, and was supposed posed to stay in its assigned room. Staff were not supposed to switch the call light boxes and were expected to report all call lights not working. No routine battery changes or maintenance checks occurred because the system alerted maintenance when batteries needed replacement. The system needed to be reset because it was overloaded. The company was contacted that day to test the system. New equipment was ordered to improve the signals to the rooms as the receiver may not have enough strengths to transmit signals within the room. The 2/20/19, Call Lights policy identified all facility personnel must be aware of call lights at all times. Staff were to check all call lights daily and report defective lights to the charge nurse immediately. Log defective lights with exact location in maintenance logs if the facility had such a log. The policy did not include how to reset call lights or what to do if the call light system was not functioning properly.