DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 7I28
Facility ID: 00407

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245395**

2. STATE VENDOR OR MEDICAID NO. (L2) **146319500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CROSSROADS CARE CENTER**
(L4) **965 MCMILLAN STREET**
(L5) **WORTHINGTON, MN** (L6) **56187**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/20/2020** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Charity Borresen, HFE II 09/28/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/16/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **01/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
September 10, 2020

Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

RE: CCN: 245395
Cycle Start Date: August 20, 2020

Dear Administrator:

On August 20, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 25, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 25, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 25, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 25, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Crossroads Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 25, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 20, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

Hand Hygiene

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review hand hygiene policies and procedures to ensure they meet CDC guidance, and revise as needed.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into staff training.
- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

https://www.health.state.mn.us/people/handhygiene/ (MDH)
Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html
Hand Hygiene for Health Professionals (MDH)
https://www.health.state.mn.us/people/handhygiene/index.html
Cleaning Hands with Hand Sanitizer (MDH)
https://www.health.state.mn.us/people/handhygiene/clean/index.html
CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm
WHO Guidelines on Hand Hygiene in Health Care (WHO)
https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf;jsessionid=A770590E49844880F6F3E1D8F22F0841?sequence=1

Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO)
https://www.who.int/gpsc/5may/hh_guide.pdf

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.
- The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAA Committee members and members of the Governing Body
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the “Item” column

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/17/20 through 8/20/20, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their	E 037		10/1/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/18/2020

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.

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 1 expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the	E 037		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 2 following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:	E 037		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 3 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: 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.	E 037	E037 1. Employment files of new hires dating back to May 1 will be audited to identify if the online Emergency Preparedness (EP) training had been completed through Healthcare Academy.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 4 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.	E 037	2. Employees found not to have completed EP will be notified and assigned to complete the training. 3. The HR Coordinator will ensure emergency preparedness training training has been completed by 10/1/2020. 4. The HR Coordinator will ensure all new hires complete EP training upon hire and prior to employees beginning their assigned work duties. 5. The HR Coordinator and/or designee will be responsible for compliance. 6. Audits for emergency preparedness training will begin weekly x 4 weeks then monthly to ensure compliance. 7. The results of those audits will be sent to QAPI to determine the need for compliance or continued monitoring. Date: 10/1/2020	
F 000	INITIAL COMMENTS	F 000		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 5 On 8/17/20, through 8/20/20, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5395018C with a deficiency cited at F580 and H5395023C with a deficiency cited at F919. H5395019C, H5395021C, and H5395022C were also substantiated, however NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F 558		10/1/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 6 other residents. This REQUIREMENT is not met as evidenced by: 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 of dementia, Alzheimer disease, with difficulty walking and severely impaired cognition. 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	F 558	F558 1. R29 and R485 had their call lights within reach immediately upon notification from the surveyor by RN-A. All existing resident call lights were checked for functionality during the survey. Maintenance will ensure that a call light box with cord is installed in each room for each resident. 3. Call lights will be checked before admission to ensure functionality. For call lights that are not working, residents will be placed in a room with a working call light. 4. Nursing and CNA staff will be re-educated on the call light policy emphasizing that call lights must be within reach of the residents. 5. Maintenance Director and/or designee is responsible for audit and compliance. 6. Audits for call light functionality and if call light is in reach of the resident beginning 10 rooms daily x 5 days, 10 rooms weekly x 2 weeks then monthly to ensure compliance. Any call-light found not to be in working order will be repaired immediately. 7. Audits will be reviewed by the Administrator and the results of those audits will be taken to QAPI for review and recommendation. Compliance date: 10/1/2020	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 7	F 558		

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 of stroke, vascular dementia with behavioral disturbance, and major depressive disorder severe with psychotic symptoms.

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 8 ensure the call light was within easy reach of the resident.	F 558		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other	F 565		10/1/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 9 residents in the facility. This REQUIREMENT is not met as evidenced by: 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	F 565	F565 1. Resident council minutes from 6/9/2020, 7/9/2020 and 8/13/2020 will be reviewed by the Administrator and Social Services Designee and those concerns will be addressed via a grievance form and the concern will be discussed with the residents R1, R3, R5, R8, R14, R18, R20, R23 and R32 for their comments and the resolution will be recorded. 2. Resident council concerns from future meetings will be placed on a grievance form and taken to the appropriate department for resolution and resident satisfaction. Upon admissions, residents will be educated on the resident council committee and grievance procedure. 3. The IDT team will be in-serviced on the grievance policy and procedure on 9/21/2020. 4. Grievances will be reviewed monthly during QAPI to identify trends/patterns. Residents will also be educated on the grievance procedure at the next scheduled resident counsel tentatively scheduled for 9/24/2020. 5. Audits on resident counsel minutes and grievances will begin weekly x 3 weeks then monthly to ensure compliance. 6. Social Services Designee and/or designee will be responsible for compliance. 7. Audits will be reviewed by the administrator and the results of those audits taken to QAPI for review and	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 10 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	F 565	recommendation. 8. Compliance: 10/1/2020	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 11 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 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 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		10/1/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: 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	F 580	F580 1. R2 family was notified on 8/17/2020 regarding the incident on 6/6/2020. This notification will be added to the incident report. All other incidents from survey exit will be reviewed and updates for notification will be made. R2 care plan was reviewed and updated as needed. 2. Future resident incidents, family/representatives will be notified by	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13 (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 7/23/20, indicated diagnosis of dementia with behavioral disturbance. 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	F 580	the nurse initiating the risk management. 3. Nursing staff along with the IDT team will be in-serviced on the resident to resident altercation policy and procedure along with emphasis on family notification beginning 9/21/2020. 4. Audits on risk management incidents and family representative notification will begin weekly x 3 weeks then monthly to ensure compliance. 5. DON and/or designee is responsible for compliance. 6. Audits will be reviewed by the Administrator and the results taken to QAPI for review and recommendation. Compliance: 10/1/2020	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14	F 580		

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.

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 15 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 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		10/1/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 16 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: 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.	F 584	F584 1. R29 and R9 rooms were terminally cleaned on 8/21/2020. All other resident rooms will be cleaned per housekeeping cleaning schedule. Resident rooms that require repair will be placed on the maintenance log and repairs will begin as soon as possible after notification. 2. Staff will be in-serviced on procedures for reporting equipment repair. Housekeepers will also be in-serviced on the terminal cleaning policy and procedure beginning 9/21/2020. Maintenance Director will review the repair/maintenance log 2x day and will prioritize work orders as needed. 3. Maintenance Director and/or designee is responsible for compliance. 4. Maintenance will conduct audits on room cleanliness and maintenance log will begin daily x 10 days, weekly x 3 weeks then monthly to ensure compliance.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 17 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	F 584	5. Audits will be reviewed by the Administrator and the results taken to QAPI for review and recommendation. 6. Compliance: 10/1/2020	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 18	F 584		

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 19 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	F 584		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 20 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 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 584		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: 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:	F 657	F657 1. R1 and R19 risk management fall incidents were reviewed and updated 9/21/2020. Both residents care plans were reviewed, and appropriate fall interventions were added and/or updated as needed. All other residents that are high risk for falls were reviewed and their	10/1/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22 R19's current diagnosis report included history of falling, Alzheimer's disease, behavioral disturbance, history of transient ischemic attack (stroke), and legally blind. R19's quarterly Minimum Data Set assessment dated 6/18/20, 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	F 657	care plans were updated as needed. Fall incidents from survey exit will be reviewed and appropriate interventions will be added to the incident and care plan accordingly. Future residents will have their fall care plan initiated per policy and updated accordingly. 2. Nursing staff will be in-serviced on the Kardex feature in the electronic medical record and where to locate interventions in the resident care plan. The IDT team will review each fall and ensure that appropriate interventions are added to the care plan during morning meeting clinical review. 3. Audits for fall interventions, Kardex location and risk management incident completion will begin daily x 10 days, weekly x 4 weeks then monthly to ensure compliance. 4. DON and/or designee is responsible for compliance. 5. Audits will be reviewed by the Administrator and the results of those audits will be taken to QAPI for review and recommendation. 6. Compliance: 10/1/2020	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23 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	F 657		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24	F 657		

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25	F 657		

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 falls with and without minor

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657		F 657		

Continued From page 26
injury since last admission.

R1's 8/19/20, diagnoses included dementia, Major Depressive Disorder, schizophrenia, bipolar disorder 2, polyosteoarthritis, fibromyalgia, inflammatory polyneuropathy, diabetes type 2 with neuropathy, high blood pressure, and history of cancer.

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 fibromyalgia, polyneuropathy, polyosteoarthritis. 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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 27 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.	F 657		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 28 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 fracture of the nasal 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, and Afrin nasal 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	F 657		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29	F 657		

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30	F 657		

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 hydrocodone. 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.

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 31	F 657		

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.

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 32	F 657		

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 insomnia 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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 33 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 657		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		10/1/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 34 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: 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 of: gastroesophageal reflux disease without esophagitis, asthma, major depressive disorder,	F 755	F755 1. R5 and R6 MD and family were called to notify of this incident. R5 and R6 will have a new self-administration medication assessment completed on 9/18/2020. R5 and R6 self-administration care plan will be reviewed or initiated and updated accordingly. All other residents will be assessed for self-administration of medication and their care plan will be updated accordingly. R5 order for the inhaler medication will be updated to	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 35 barretts esophagus without dysplasia, anxiety, and osteoarthritis. 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 2/13/20 and 5/18/20 identified staff marked "No/unable to determine" and continue with current plan of care. R5's quarterly MDS dated 5/20/20 identified cognitive function with a BIMS of 2, severe cognitive impairment and usually understands direction. R5's admission record included diagnoses of: dementia, Alzheimer, chronic obstructive pulmonary disease (COPD), epilepsy, emphysema, disorientation, amnesia, weakness. 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	F 755	include a mouth rinse following administration. Refusals will be recorded in the resident□s medical record. 2. Nursing staff was in-serviced on 8/24/2020 on self-administration of medication policy along with medication administration policy on 9/21/2020. 3. DON and/or designee is responsible for compliance. 4. Audits for self-administration of medication assessment, care plan and medication administration will begin 2x a week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. 5. Audits will be reviewed by the Administrator and the results of those audits will be taken to QAPI for review and recommendation. 6. Compliance: 10/1/2020	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 36 does not want to do mouth rinses. Record review of R5's medication orders indicate Budesonide-Formoterol Fumarate Aerosol 160-4.5 mcg/ACT 2 puffs inhale orally two times a day for Emphysema/COPD. 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 self-administration for residents if able to take medications without being witnessed by nurse. DON stated she would expect the mouth to be rinsed after inhalers as ordered and would expect the nurse to attempt to instruct resident. Record review of Administering Medications Policy last reviewed on 11/6/19 included the following: medications must be administered in 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 755		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		10/1/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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	F 880	F880 1. R6, R12, R23, R5, R31 and all residents residing on the south wing of the facility were assessed for any adverse effects from this deficient practice on 8/20/2020. Their MDs will be notified, and his/her response will be documented in the resident medical record. Immediate education hand hygiene was provided by the DON to the nurse aide and housekeeping staff during the survey. The Housekeeping Director will be provided the room cleaning policy to review on 9/21/2020. The MD will be updated on this deficient practice. 2. Staff will be in-serviced on the hand hygiene policy and housekeeping staff will be in-serviced on the room cleaning policy	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 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.	F 880	and procedure and environmental cleaning product procedure with emphasis on kill time beginning 9/21/2020. The infection preventionist will review the infection control program policy on 9/21/2020. 3. The DON and/or designee is responsible for compliance. 4. Audits on hand hygiene, room cleaning and housekeeping staff competency on cleaning product sanitation kill time beginning: 2x a week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. 5. Audits will be reviewed by the Administrator and the results of the audits will be taken to QAPI for review and recommendation. 6. Compliance: 10/1/2020	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 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	F 880		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 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 nitrile 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	F 880		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42	F 880		

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,

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43 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 880		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 3 residents	F 919	F919 1. R3, R19 and R25 call lights were	10/1/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 44 (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. The call light unit's light	F 919	repaired on 8/18/2020 and 8/19/2020. All other resident call lights were tested during survey for functionality and repairs were initiated. Call lights will be checked before admission to ensure functionality. For call lights that are not working, residents will be placed in a room with a working call light. In the event of future call light outages, 15-min rounds will be initiated by facility staff and the maintenance director will be notified for troubleshooting/repair. 2. Facility call light equipment and software upgrades will be completed by 10/10/2020. Maintenance Director, Administrator and DON will be educated by the software installer on functionality of the system during installation. Facility staff will be in-serviced on the call-light policy and procedure beginning 9/21/2020. 3. Maintenance Director and/or designee is responsible for compliance. 4. Audits on call light wait time, call light within reach of the resident, along with functionality will begin daily x 10 days, weekly x4 weeks then monthly to ensure compliance. 5. Audits will be reviewed by the administrator and the results of those audits will be taken to QAPI for review and recommendation. 6. Compliance: 10/10/2020	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 45	F 919		

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 213'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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 46 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	F 919		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 47	F 919		

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 48	F 919		

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.

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 49 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.	F 919		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Crossroads Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/18/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crossroads Care Center was constructed as follows: The original building was constructed in 1953, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1968 Addition is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 35 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits	K 271		9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 271	Continued From page 2 Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain (7.7, 7.1.7, 19.2.7) in accordance with the Life Safety Code (NFPA 101) 2012 edition. This deficient practice could affect: 35 residents On facility tour between 09:00 AM and 01:00 PM on 08/18/2020, observations and staff interview revealed the following: During the walk-through inspection of the facility greater-than ½" vertical transitions to grade was observed at the following points of discharge from exits: SW exit door, S Patio exit door This deficient practice was confirmed by the Facility Maintenance Director & Administrator at the time of discovery.	K 271	K271 1. The vertical transitions at the SW exit and south patio were repaired with an all-weather material so that they are at grade. 2. The repair was completed on August 28, 2020. 3. The Maintenance Director or his designee will periodically inspect the vertical transitions and ensure they remain at grade.	
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain (9.6.1.3, 9.6.1.5) in accordance with the Life Safety Code (NFPA 101) 2012 edition. This deficient practice could affect: 35 residents On facility tour between 09:00 AM and 01:00 PM on 08/18/2020, observations and staff interview revealed the following: During the walk-through inspection of the facility observed obstructed access to fire alarm pull stations in the following locations: Memory Care Unit, Staff Dining Area This deficient practice was confirmed by the Facility Maintenance Director & Administrator at the time of discovery.	K 345	K345 1. The objects that were obstructing access to fire alarm pull stations in the memory care unit and staff dining area were moved away from the fire alarm pull stations. 2. The objects were moved on the date of the survey, August 18, 2020. 3. The Maintenance Director or his designee will monitor and ensure all fire alarm pull stations remain free from obstructions.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test	K 353		9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain (9.7.5, 9.7.7, 9.7.8) in accordance with the Life Safety Code (NFPA 101) 2012 edition. This deficient practice could affect: 35 residents On facility tour between 09:00 AM and 01:00 PM on 08/18/2020, observations and staff interview revealed the following: During the walk-through inspection of the facility observed high storage in closets and on shelving at the following locations: RM 216, RM 013, RM C210, RM E19 This deficient practice was confirmed by the Facility Maintenance Director & Administrator at the time of discovery.	K 353	K353 1. Items stored high in closets and on shelving were removed by housekeeping and direct care staff. 2. The items were removed by August 21, 2020. 3. The Housekeeping/Laundry Supervisor or her designee will monitor and ensure items are not stored high in closets and on shelving.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 5 by: Based on document review and staff interview, the facility failed to maintain (18.3.5.12, 19.3.5.12) in accordance with the Life Safety Code (NFPA 101) - 2012 edition. This deficient practice could affect: 35 residents On facility tour between 09:00 AM and 01:00 PM on 08/18/2020, observation and documentation reviewed revealed the following: During documentation review, no records were provided for review, associated to fire extinguisher monthly inspections This deficient practice was confirmed by the Facility Maintenance Director & Administrator at the time of discovery.	K 355	K355 1. A log sheet will be used to document monthly fire extinguisher inspections. 2. The log sheet was initiated Sept. 1, 2020. 3. The Maintenance Director or his designee will conduct the monthly fire extinguisher inspections and document such on the log sheet.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain (19.5.1.1, 9.1.1, 9.1.2)	K 511	K511	9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 6 in accordance with the Life Safety Code (NFPA 101) 2012 edition. This deficient practice could affect: 35 residents On facility tour between 09:00 AM and 01:00 PM on 08/18/2020, observations and staff interview revealed the following: During the walk-through inspection of the facility observed obstructed access to electrical panels in the following locations: RM C9, Laundry Storage Area During the walk-through inspection of the facility observed unsecured electrical panels in the resident corridor: Memory Care Wing This deficient practice was confirmed by the Facility Maintenance Director & Administrator at the time of discovery.	K 511	1. The objects that were obstructing the electrical panels in room C9 and the laundry storage area were moved away from the electrical panels. 2. The objects were moved on the date of the survey, August 18, 2020. 3. The Maintenance Director or his designee will ensure all electrical panels remain free of obstructions. 1. The doors of the electrical panels in the memory care unit were secured with the installation of hasps and padlocks. 2. The installation of the hasps and padlocks was completed on August 28, 2020. 3. The Maintenance Director or his designee will monitor and ensure the electrical panels remain secured.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 7 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain (10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) in accordance with the Life Safety Code (NFPA 101) 2012 edition. This deficient practice could affect: 35 residents On facility tour between 09:00 AM and 01:00 PM on 08/18/2020, observations and staff interview revealed the following: During the walk-through inspection of the facility observed appliances connected to power strips in the following locations: RM 013, RM 209, Staff Dining Area During the walk-through inspection of the facility observed the use of extension cords in the following locations: RM S31, Maintenance Shop, Laundry Storage Area During the walk-through inspection of the facility	K 920	K920 1. The power strips in rooms 013, 209, and the staff dining area were removed; the extension cords in room S31, the maintenance shop, and the laundry storage area were removed; the six-plex electrical adapter in room S31 was removed; and the tri-tap electrical adapter in the maintenance shop was removed. 2. The items were removed on the date of the survey, August 18, 2020. 3. The Maintenance Director or his designee will monitor and ensure only allowable electrical devices are plugged into power strips, and multi-plex electrical adapters and extension cords are not used in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 8 observed usage of a six-plex electrical outlet adapter connected to a single wall outlet in RM S31 During the walk-through inspection of the facility observed appliances connected to a tri-tap electrical adapter in the Maintenance Shop This deficient practice was confirmed by the Facility Maintenance Director & Administrator at the time of discovery.	K 920		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923		9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 9 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain (11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)) in accordance with the Life Safety Code (NFPA 101) 2012 edition. This deficient practice could affect: 35 residents On facility tour between 09:00 AM and 01:00 PM on 08/18/2020, observations and staff interview revealed the following: During the walk-through inspection of the facility observed the following: 1) RM S214 (Med Gas Storage - Empty) E-cylinders did not have plastic seals - but paper hang tags indicated cylinders were full 2) RM S214 (Med Gas Storage - Empty) E-cylinders were not located under or near appropriate wall signage 3) RM S216 (Med Gas Storage - Full) Mixed storage of E-cylinders 4) RM S216 (Med Gas Storage - Full) No wall signage (Empty / Full)	K 923	K923 1. All oxygen cylinders were moved into room S216. Full tanks were placed in one area with a Full Cylinders sign placed on the wall above them. Empty tanks were placed in another area with an Empty Cylinders sign placed on the wall above them. 2. The work was completed on August 21, 2020. 3. The Director of Nursing or her designee will monitor and ensure the oxygen cylinders are stored in the appropriate area and the paper hang tags appropriately indicate whether the tanks are full or empty.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____________	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 10 This deficient practice was confirmed by the Facility Maintenance Director & Administrator at the time of discovery.	K 923		