STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165275	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Haven Care Centre	1000 East Howard Creston, IA 50801

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46873 Based on clinical record review, staff, family and provider interviews, and facility policy review, the facility failed to update and revise a resident care plan to reflect non compliance with physician orders for 1 of 4 (Resident #1) residents reviewed. The facility reported a census of 27 residents. Findings include: The Minimum Data Set (MDS) of Resident #1 dated 10/10/23 identified a Brief Interview of Mental Status (BIMS) score of 13 which indicated cognition intact. The MDS revealed the resident required supervision or touching assistance for bed mobility and transfers. The MDS documented diagnoses that included high blood pressure, renal failure, diabetes mellitus, anxiety, depression, chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues). The Comprehensive Care Plan of Resident #1, reviewed 10/17/23, identified a focus area of the resident having COPD. The care plan directed to give oxygen therapy as ordered by the physician. The Care Plan identified additional focus areas of diabetes mellitus, psychotropic drug use, chronic pain, and activities of daily living self care performance deficit. The Care Plan failed to document a history of any non compliance with any of her cares or treatments. The Health Status Note dated 1/22/24 at 1:37 pm documented the resident alert to herself only, and unable to stand with one assist per her baseline. Vital signs were normal. Orders received to transfer the resident to the emergency room . The Orders section of the Electronic Health Record (EHR) of Resident #1 identified an order for oxygen at 1-3 liters/minute via nasal cannula for COPD, titrate to resident comfort. The Treatment Administration Record (TAR) for January 2024 revealed the resident to use oxygen daily. The TAR documented Yes for behavior observed 10 times of the 41 entries for January 2024. No details of the behaviors documented in the Progress Notes. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 11:13 am, Staff A, Registered Nurse (RN) stated Resident #1 did pretty much whatever she wanted. He stated during the day, she sat in her recliner and her oxygen concentrator was within her reach. He stated she was definitely capable of adjusting the oxygen levels herself but he had never witnessed her doing so. On 5/15/24 at 11:21 am, Staff B, Certified Nurse Aide (CNA) stated the weekend prior to Resident #1 being sent to the hospital, the resident was asking staff to increase her oxygen. Staff B stated she responded she was not allowed to adjust the oxygen. She stated she had heard she was found with a higher level of oxygen on than was ordered and had heard the resident had adjusted it herself but was not sure she was strong enough to have done so. On 5/15/24 at 11:45 am, Staff C, CNA, stated it was normal for the resident to complain of being short of breath. She stated the resident was capable of turning the oxygen up herself but she had never witnessed her doing it. On 5/15/24 at 12:58 pm, Staff D, CNA (former employee) stated she recalled the resident stating she couldn't breathe and was out of air prior to her hospitalization . She stated she reported this to the nurse and the nurse assessed her. She stated this was near the end of her shift and she did not see the resident again. She reported she never witnessed the resident turning up the oxygen herself but the concentrator was next to her and she was able to reach it. On 5/15/24 at 1:06 pm, Staff E, CNA stated the resident seemed to have a cold prior to being sent to the hospital. She stated it was constant for the resident to complain of having a hard time breathing and that day was no different. She said the resident often requested her oxygen to be turned up but the CNA's told her no as they were not allowed to adjust oxygen. She reported the nurse assessed the resident. Staff D reported the resident at times would adjust the oxygen on her own but the nurse would turn it back down. She said she had never witnessed the resident adjusting it but knew her oxygen had been found adjusted too high and staff would turn it back down. On 5/15/24 at 1:11 pm, Staff F, CNA stated the resident had reported having a hard time breathing and she had notified the nurse. She stated the resident requested to have her oxygen increased a couple of times that weekend. She stated nothing was out of the ordinary for the resident that weekend except looking a little pale on the day she was sent to the hospital. She said she never witnessed the resident adjusting her oxygen herself but she would request staff to do it and she would be told no, then they would find it increased later. She stated when she found the oxygen settings increased, she would notify the nurse to adjust it. She reported the oxygen was within the reach of the resident. On 5/15/24 at 1:24 pm, Staff G, RN, and former Director of Nursing (DON) stated the resident had a history of adjusting her oxygen levels. She said Resident #1 would lean over from her recliner and adjust the concentrator. She said she had provided education for her not to adjust it and the resident would state ok. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 2:26 pm, a family member of the resident stated the resident had told her that she needed to go to the emergency roiagnom on the weekend prior to her hospitalization . The family member notified the facility and they told her they would assess her and keep an eye on her. She reported this behavior was normal for her and had been happening for years. She recalled the facility called her on the date the resident was sent to the hospital and said the resident's vital signs were stable but she didn't seem herself and they were sending her to the hospital. She stated when she arrived at the emergency room , she saw the resident wearing 4 liters of oxygen and asked the staff why. She was told when the emergency services picked her up from the facility, she was wearing 4 liters so that is the level they kept her on. The hospital staff adjusted the oxygen to 2 liters per the family member request. She reported the facility told her they thought the resident had adjusted the oxygen herself but she was unsure if the resident did or not. She said she had seen the oxygen concentrator out of the resident's reach on prior visits due to the resident adjusting it herself in the past. She described the resident as very feisty and stated if the oxygen had been within her reach, she would guarantee the resident would have turned it up. On 5/15/24 at 3:14 pm, the MDS Coordinator stated in the past, they had attempted to move the resident's oxygen concentrator out of her reach. She said the resident used the oxygen tubing to pull the machine (machine was on wheels) back to within her reach. She reflected the resident was often an attention seeker. She stated she had been a charge nurse until January of 2024, shortly before the resident was transferred to the hospital. She had just become the MDS Coordinator in January. She reported she does baseline care plans, and the corporate MDS Coordinators do the full care plans. She stated her routine at this time is to notify the corporate MDS nurse if something on a care plan needs updated. On 5/15/24 at 3:26 pm, Staff G, RN, former DON, stated the resident had a BIMS of 15, and they did talk to her about not adjusting the oxygen levels herself. She stated at one time, they had placed a sign on the concentrator reminding the resident not to adjust the oxygen levels. She stated she did not know if this should have been placed on the care plan or not as she did not consider it to be excessive behavior. She stated she was not aware of whose responsibility it was at that time to update the care plans. On 5/15/24 at 3:42 pm, Staff I, RN stated the resident would occasionally adjust the oxygen levels herself. She believed the resident's oxygen was at 3 liters the day she was sent to the hospital. On 5/15/24 at 3:50 pm, the Nurse Practitioner stated the resident was very non compliant. She stated she was aware of times the resident would turn her oxygen concentrator up and when staff noted it, they would turn it back down. She relayed she was not sure of how frequently this was an issue but she had a history of other non compliance. She listed examples of the resident being non compliant with weight bearing orders and working with therapy when she previously had a broken knee, as well as not following orders on a prior wound she had. She reported the resident would listen to education but would not follow directions. She stated during her visits with the resident, the oxygen concentrator was between the residents chair and her bed. If it was not within the resident's reach, she stated the resident had enough strength she would lean over her chair and pull it to within her reach. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 4:11 pm, Staff J, Corporate MDS nurse commented she completed the care plans based on the Care Area Assessments triggered on the MDS. She stated for any significant changes to the resident, she updated those on the care plan but the day to day updates were the responsibility of the facility. She stated as she completed the MDS, she reviewed progress notes but she did not see any progress notes regarding the resident being non compliant with her oxygen so she did not place this on the care plan. She stated she works remotely, not at the facility, so she would not be aware to place this on the care plan unless she was notified by the facility or it was documented in progress notes. On 5/15/24 at 4:14 pm via email, the Administrator stated an initial care plan is to be started at the facility with the remainder of the care plan being completed by a corporate MDS nurse. She stated updates to the care plan are done by the facility. The facility policy Care Plan Development, dated 8/2015, included the following documentation: An individualized, comprehensive care plan using the results of the RAI/MDS assessment, resident/family/ legal representative and interdisciplinary input will be developed for each resident in the facility within 21 days of admission or 7 days after the completion date of a comprehensive MDS assessment, and describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan will include measurable objectives, interventions, goals, and timetables. The care plan will be reviewed and revised on an as needed basis and at least every 92 days. Point 3 - Comprehensive care plans are designed to: - Include identified resident needs and strengths - Include risk factors associated with needs - Build upon resident strengths and abilities - The care plan will be reviewed and revised as needed, when a significant change in condition is noted, when outcomes were not achieved or when outcomes are completed, and at least every 92 days. Point 4 - The care plan is integral to the provision of care to the resident and will be available to team members who are responsible for providing care and services. The completed care plans will be maintained in the resident's clinical record. All team members are responsible for reporting any changes to the resident's condition to the primary/charge nurse and of any goals or objectives not being met. Any changes must be reported to the MDS coordinator for review. Documentation must be consistent with the resident's plan of care and revisions will be done on an as needed basis and can be done by any member of the Interdisciplinary team.