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	07/11/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, family interview, staff interviews and facility policy review, the facility failed to notify the family and/or physician of a medication error, a fall and a significant change for 4 of 6 residents reviewed (Resident #3, #24, #26, and #34). The facility reported a census of 30 residents. Findings include: 1. Observation of medication pass began on 7/9/24 at 7:35 am with Staff A, Registered Nurse. Staff A first administered medications to Resident #26. The administration of 18 medications were observed for Resident #26. Of the 18 medications administered, three of the medications were medication errors of the incorrect dosage. Following administering the medications to Resident #26, Staff A then administered Medications to Resident #3. One medication error was noted for Resident #26, also being an incorrect dosage. On 7/9/24 at 8:30 am, the Director of Nursing (DON) stated if a stock medication does not match the order, the nurse should notify the doctor and get an order change or get the correct dose from the pharmacy based on the doctor's preference. Review of the Progress Notes for Resident #26 and Resident #3 on 7/11/24 failed to reveal the physician had been notified of either resident having been administered medications not matching physician orders. 2. On 7/8/24 at 12:49 pm, a nurse at Resident #34's prior nursing facility stated she had come to visit Resident #34 at the current facility on 6/6/24. She stated she noticed a bruise on the resident's forehead and said Resident #34 had told her she had fallen out of her chair and also told her she was having pain in her legs. The nurse stated after the visit, she called Resident #34's family member who was not aware of Resident #34 having fallen or having any bruising or pain. On 7/8/24 at 1:50 pm, a family member of Resident #34 stated he had not been notified by the facility of Resident #34 having fallen or having any injuries. He stated he had not been aware of this until the nurse from the prior nursing facility informed him. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Profile section of Resident #34's Electronic Health Record reflected the son of Resident #34 to be: - Responsible Party - Financial Responsible Party - Power of Attorney, Financial - Power of Attorney, Care - Emergency Contact #1 The Minimum Data Set (MDS) assessment of Resident #34, dated 5/27/24 identified a Brief Interview of Mental Status (BIMS) score of 7 which indicated severe cognitive impairment. The Risk Management form dated 6/3/24 documented Resident #34 was observed on the floor beside her bed, lying on her stomach. It revealed documentation the resident stated she was self transferring to her bed and slid off the side of the bed. Page 3 of the Risk Management document revealed the Nurse on call and the Physician were both notified of the incident. The Risk Management form failed to document the Power of Attorney/Emergency Contact for Resident #34 was notified. Review of Resident #34's Progress Notes failed to reveal any documentation of the Power of Attorney/Emergency Contact for Resident #34 being notified of the fall. On 7/11/24 at 12:27 pm, the DON stated staff should notify family for falls and/or change of condition as soon as possible for injuries and within an acceptable time for family preference unless the resident competently represents themselves. 50471 3. The MDS assessment dated [DATE] for Resident #24 identified a BIMS score of 4 which indicates severe cognitive impairment. The MDS revealed the resident to need minimal assistance with personal care and dressing. Resident is dependent on staff for toileting hygiene and shower/bathe self. The MDS documented diagnoses that included: cerebral infarction, unspecified, Non-Alzheimer's dementia, hemiplegia, depression, and vascular dementia. The Care Plan, revised 3/5/24, revealed resident incontinent of bowel and bladder, staff to encourage resident to toilet before and after each meal, at bedtime, and at least once during the night, Check him for incontinence at that time, staff to assist as needed. Revealed resident sometimes needs some help with sit to stand, resident is able to transfer independently with his walker. Revealed resident is usually able to toilet independently, resident does need cues and assist to complete toileting hygiene and needs reminders to change soiled clothing. The Progress Note of Resident #24 dated 6/28/24 at 7:24 PM documented: Daughter was updated, resident was found in another resident's room, exposed to marijuana. Daughter voiced concern about exposure to marijuana interacting with medications and comorbidities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Progress Note dated 6/28/24 at 10:27 PM noted blood pressure of 82/60. Resident stated to Staff P, Licensed Practical Nurse (LPN) I think someone's trying to kill me. Staff P, LPN asked who and why he thinks that, resident stated I'll tell you tomorrow, I forgot how to talk. The Progress Note dated 6/29/24 at 12:04 AM noted blood pressure 112/63. Resident stated to staff I'm ok. The Progress Note dated 6/29/24 at 2:02 AM noted blood pressure 117/66. The Progress Note dated 6/29/24 at 4:00 AM noted blood pressure 119/68. On 7/9/24 at 4:09 PM Staff Q, Certified Nurse Aide stated on 6/28/24 she worked 6:00 PM to 6:00 AM shift. She stated Resident #24 baseline is stand by assist. She took care of Resident # 24 that evening and resident required maximum assistance to total assistance of one staff to complete personal cares and toileting. Staff stated this is not his normal, he is very out of it. She stated she reported to the nurse on shift. On 7/10/24 at 6:32 AM Staff P, Registered Nurse (RN) stated on 6/28/24 at 6:30 PM, Resident #24 was found smoking marijuana, in Resident # 11 room, she removed the resident from the room and assisted the resident to his room. She monitored the resident the remainder of the shift. She noted during shift the resident was having delusions, people were trying to kill him. Staff stated she updated doctor via fax. Staff stated she did speak with the Doctor regarding resident #11, but did not update the doctor about resident #24 having delusions. Staff stated the resident does not have delusions of someone killing him at baseline. On 07/11/24 at 2:43 PM Staff P, LPN stated the resident has delusions at baseline. The residents delusions come and go. The resident is seen by a Psychiatrist. Staff P stated the resident needs assistance from staff most of the time for cares, and transferring varies depending on his status that day. The facility policy titled Notification of Resident/Patient Change in Condition, Review date 11/2019 directs: Point 7: Notify the Physician and family/resident representative at the earliest possible time, during waking hours, if there is a change in condition. Point 10: Document in the Progress Notes the times notification was made and the names of the person(s) spoken to.

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

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(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 - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, clinical record review, resident interview, staff interviews, and policy review, the facility failed to fully review and revise the comprehensive care plan for 4 of 15 resident reviewed (#11, #12, #26, and #34). The facility reported a census of 30. Findings include: 1. An observation on 7/08/24 at 3:25 PM revealed Resident #26's legs and feet were swollen. The resident stated she was taking a water pill (diuretic) for a while for the swelling in her legs. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of hypertension, deep vein thrombosis (DVT; deep vein blood clot), hyperlipidemia (high cholesterol in the blood), diabetes mellitus, and morbid obesity. It revealed the resident was independent with eating and oral hygiene, required maximum assistance with upper body dressing, and was dependent in all other activities of daily living (ADLs) and all mobility. It also revealed the resident received a diuretic within the 7-day look-back period. The Electronic Health Record (EHR) included a diuretic medication order dated 11/03/23. A physician's order dated 1/23/24, increased the diuretic dose. The Care Plan did not include the resident's use of diuretic medication nor interventions. On 7/11/23 at 12:27 AM, the interim Director of Nursing (DON) stated Care Plans should be continuously revised to meet the needs of the resident's care. A document titled Care Plan Development dated 8/15 indicated the Care Plan will be reviewed and revised on an as needed basis and at least every 92 days. 50471 2. The MDS assessment dated [DATE] for Resident #11 identified a BIMS score of 15 which indicates cognition intact. The MDS revealed the resident totally dependent upon staff for all cares. The MDS documented diagnoses that included: quadriplegia, anxiety disorder, depression, autonomic dysreflexia, and muscle spasms. The Comprehensive Care Plan of resident #11 initiated 10/11/22 failed to reveal resident to be a smoker. The untitled facility document provided during survey listed 4 residents as smokers which included Resident #11. Observation on 7/9/24 at 2:41 PM, revealed Resident # 11 is dependent on staff for monitoring during vaping at the designated facility times and place. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Smoking: Resident/Patient Overview revised 9/19 included the following documentation: Evaluation/Assessment will include but is not limited to, the Admission/Re-Admission Documents & Initial Care Plan, Smoking Safety Screen, The RAI/MDS, and Physician orders. 3. The MDS assessment dated [DATE] for Resident #12 identified a BIMS score of 4 which indicates severe cognitive impairment. The MDS revealed the resident totally dependent upon staff for all cares with exception of eating. The MDS documented diagnoses that included: unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, non-Alzheimer's dementia, seizure disorder or epilepsy, anxiety disorder, schizophrenia, and dysphagia. The Care Plan of resident #12 revised 2/27/24 reveals the resident transfers with assistance of one staff member, the resident requires (supervision, cueing, encouragement, specify physical assistance) with transferring, and the resident can transfer with one assist and use of his walker. Assist as requested or as needed. The Progress Note dated 1/26/24 at 3:02 PM revealed the Social Worker (SW) states Resident #12 brother called facility, SW updated brother on the decline in condition. SW provided details of decline stated staff is assisting with meals and staff uses a Hoyer to transfer him into a wheelchair. On 7/08/24 at 1:20 PM Resident #12 observed sitting in wheelchair with a sling for a full body mechanical lift under him. On 7/09/24 at 1:15 PM Staff L, Certified Nurse Aide (CNA) assisted Resident #12 to his room. Staff K, CNA assisted Staff L. Staff gathered mechanical lift equipment, instructed resident of the task, permission granted, staff hooked up mechanical lift to sling, Staff L controlled the mechanical lift equipment, Staff K guided resident to bed, resident positioned over bed, Staff L lowered resident onto the bed. Staff unhooked the sling from the lift. Staff moved the mechanical lift away from the bed. On 7/11/24 at 12:27 PM, the Director of Nursing (DON) stated Care Plans should be continuously revised to meet the needs of the resident's care. On 7/11/24 at 3:50 PM Staff P, Licenses Practical Nurse, Nurse Manager stated she does not do care plan revisions. On 7/11/24 at 4:04 PM the Regional Director of Nursing stated MDS Coordinators are remote. He stated any care plan areas that trigger on the Care Area Assessments (CAA) of a comprehensive MDS are the responsibility of the remote MDS Coordinator to care plan. Daily updates should be done within the facility, and that is the responsibility of Staff P, LPN or of the DON. The facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,d+[DATE] includes the following documentation: Comprehensive or full assessments include the admission, significant change, significant correction of a prior full assessment and annual include all required MDS items along with State-designated sections, use of Care Area Assessment (CAA) including CAT's and CAA summary. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Within 14 days after the facility determines that there has been a significant change in the resident's status that will not normally resolve itself, which has an impact on one or more area of the residents' health status and requires an interdisciplinary review and/or revision of the care plan. 46873 4. The Minimum Data Set assessment of Resident #34, dated 5/27/24 identified a Brief Interview of Mental Status (BIMS) score of 7 which indicates severe cognitive impairment. The Care Plan of Resident #34 revealed a focus area of Actual Fall related to poor balance and unsteady gait dated 6/4/24. The intervention put in place was to monitor for 72 hours. No intervention was put in place to prevent or reduce future falls. The Risk Management form dated 6/3/24 at 8:45 pm documented Resident #34 was observed on the floor beside her bed, lying on her stomach. It revealed documentation the resident stated she was self transferring to her bed and slid off the side of the bed. The form noted no injuries observed at the time of the incident or post incident. On 7/10/24 at 1:17 pm, the Regional Director of Clinical Services stated a Risk Management form should be started by the nurse on duty at the time of the incident. From there, there should be a full investigation of the incident and it would be discussed in the morning meeting on the next business day. He stated during the meeting, it should be assured an intervention was put in place on the resident's care plan. If the intervention initially put in place was not an appropriate intervention, it would be changed. He additionally stated follow up assessment and charting by the nurses should be completed for 72 hours after an incident. The facility policy Fall Risk Reduction & Management, revision date 12/2015 documented the following: The Interdisciplinary team will develop a care plan for all residents/patients requiring a fall management program. The interdisciplinary team will develop the care plan with input from the resident/patient and/or the family/responsible party. Point 2: Develop the goal for fall risk reduction with the resident/patient and/or family/responsible party. Point 3: Develop interventions to assist resident/patient in reaching their goal.

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	165275	A. Building B. Wing	07/11/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46873

Based on clinical record review, family interviews, staff interview and hospital record review, the facility failed to perform complete and accurate assessments following a fall for 1 of 1 residents reviewed for falls (Resident #34). The facility reported a census of 30 residents.

Findings include:

The Minimum Data Set assessment of Resident #34, dated 5/27/24 identified a Brief Interview of Mental Status (BIMS) score of 7 which indicated severe cognitive impairment. The MDS documented the resident admitted to the facility on [DATE].

The Risk Management form dated 6/3/24 at 8:45 pm documented Resident #34 was observed on the floor beside her bed, lying on her stomach. It revealed documentation the resident stated she was self transferring to her bed and slid off the side of the bed. The form noted no injuries observed at the time of the incident or post incident.

The Progress Notes for the resident documented the following:

On 6/4/24 at 3:12 am nurse summoned to resident room earlier. Resident found on stomach lying next to her bed. Resident stated she had been attempting to self transfer and slid off the side of the bed. Resident denied injury, and denied pain. Neuro's started.

On 6/4/24 at 5:31 pm resident had a previous fall with no injuries, pain or bruising.

On 6/5/24 at 5:45 pm resident denied pain from previous fall and stated she is fine.

On 6/10/24 at 9:00 am resident discharged to another facility.

The Progress Notes failed to reveal any other fall documentation, assessments, vitals or neuro's.

On 7/8/24 at 12:49 pm, a nurse at Resident #34's prior nursing facility stated she had come to visit Resident #34 at the current facility on 6/6/24. She stated she noticed a bruise on the resident's forehead and said Resident #34 had told her she had fallen out of her chair and also told her she was having pain in her legs.

On 7/8/24 at 1:50 pm, a family member of Resident #34 stated the resident discharged from the facility and transferred to another nursing facility a few days after her fall. He stated after continuing to complain of pain at the new facility, x-rays were taken and it was discovered the resident had a fractured leg. He stated she had no falls at the new facility but the fracture was discovered there.

Hospital records of Resident #34 dated 6/25/24 revealed documentation the resident was found to have a right distal femur fracture with timeline of the injury being undetermined.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 1:17 pm, the Regional Director of Clinical Services stated a Risk Management form should be started by the nurse on duty at the time of the incident. From there, there should be a full investigation of the incident and it would be discussed in the morning meeting on the next business day. It should be assured an intervention was put in place on the resident's care plan. He stated follow up charting by the nurses should be completed for 72 hours after an incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471 Based on clinical record review, facility document review, observation, staff interviews, and facility policy review, the facility failed to provide an environment that is free from accidents/hazards for 2 of 5 residents reviewed for environmental hazards (Resident # 11, #9). The facility reported a census of 30 residents. Findings include: 1. The facility document titled 5 Day Investigation Summary documented information which included the following: Staff F, Registered Nurse, (RN) was walking down the east hall at 6:30 pm on 6/28/24 when she observed the door to Resident #11's room slightly ajar and saw a male in the room. Staff F, RN entered the room and observed it was hazy with an odor of marijuana present with Resident #11 and two additional residents. Staff F observed two vapes lying on Resident #11's chest as she was in her wheelchair. Staff F separated the residents and removed the vapes from the room. The Minimum Data Sheet (MDS) assessment dated [DATE] for Resident #11 identified a Brief Interview of Mental Status (BIMS) score of 15 which indicates cognition intact. The MDS revealed the resident totally dependent upon staff for all cares. The MDS documented diagnoses that included: quadriplegia, anxiety disorder, depression, autonomic dysreflexia, and muscle spasms. The Comprehensive Care Plan of Resident #11, initiated 10/11/22, failed to reveal resident to be a smoker. The untitled facility document provided during survey listed 4 residents as smokers which including resident #11. The Progress Notes dated 6/28/24 at 8:46 PM revealed Staff F, RN walked by resident #11 room, seen a male in the room, smelled an odor at the door, and entered the room. Staff F, RN found resident #11, resident #24, and resident #30 in the room, noted a strong odor, and saw two vapes on Resident #11 right side of the chest. Staff F stated she removed the two vapes and asked resident #24 and #30 to exit the room. Resident #11 went to the front desk with sister, requested Staff F to return the two vapes. Staff F instructed resident #11 to discuss with management. Resident #11 left facility with sister. Observation on 7/9/24 at 2:41 PM, revealed Resident # 11 is dependent on staff for vaping. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 6:32 AM, Staff F recalled incident on 6/28/24 at 6:30 PM. Staff F, RN stated she walked back from vending machines at end of East hall toward Nurse Station/Center of building. She noted odor in hallway. Seen Resident #11 door was slightly opened Staff F seen male figure in room. Staff F entered room noted haze with strong odor present. Resident # 11 in w/c facing door way, Resident # 24 sitting in w/c facing window, and Resident # 30 was standing by end of bed. Staff F asked male residents to exit the room and return to their rooms. Staff F observed two vapes sitting on Resident # 11 chest. Staff F removed the two vapes and placed them in a locked area. Staff F called on call manager who updated Administrator. Staff F was instructed to call local Police Department. Resident # 11 and Resident # 11's sister went to Nurse's Station. Resident # 11 told nurse she was leaving and left the facility with sister. Local Police Officer arrived at 7:00 PM, Staff F updated Officer of incident. Officer took items and left facility. Resident # 11 arrived back to facility at 9:39 PM, noted intoxication. Staff F assessed resident #11, and updated doctor. Doctor stated to send to hospital for evaluation. Staff F updated Resident # 11, EMT's arrived evaluated, Resident # 11 refused to go to the hospital. Staff F updated doctor, ordered to monitor. Staff F monitored resident the remainder of shift. On 7/10/24 at 2:00 PM, a Police Officer with local police, stated he arrived to the facility on [DATE] at 7:00 PM, He reported Staff F, RN told him of the incident and surrendered the two vapes. The Officer was unable to complete an investigation as resident was no longer on the property at that time, no harm was committed, no chargers were filed. He stated the two vapes were not tested . but stated one vape was nicotine and the other vape was THC. On 7/11/24 at 3:23 PM, the Social Worker (SW) stated interventions put in placed, resident #24 room was changed, re-educated about facility tolerance, reviewed smoking policy, encouraged residents to meet in common area, education provided to all residents no males in females rooms and no females in males rooms. On 7/11/24 at 3:27 PM, the Administrator stated all residents had been educated about intolerance of illegal substances in facility, staff educated about situation and interventions. The facility policy titled Smoking: Resident/Patient Overview revised 9/19 included the following documentation: -Instructed staff smoking materials/electronic or vapes devices will be secured by the facility. -Designated smoking areas for residents/patients who smoke. -Evaluation/Assessment will include but is not limited to, the Admission/Re-Admission Documents & Initial Care Plan, Smoking Safety Screen, The RAI/MDS, and Physician orders. 47079 2. On 7/09/24 at 9:06 AM, Staff I, Certified Nurse Aide (CNA) transferred Resident #9 from the bathroom to her wheelchair and from the wheelchair to her bed without a gait belt. Staff I stood in front of the resident, wrapped her arms around the resident's back, and lifted the resident off of the toilet and placed her in the wheelchair. She used the same technique to transfer the resident to her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not conducted and indicated the resident was rarely or never understood. It included diagnoses of heart failure (HF), chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), and non-Alzheimer's dementia. It also indicated the resident required maximum assistance with all transfers and was dependent with tub/shower transfers. The Electronic Health Record (EHR) Fall Risk assessment dated [DATE] indicated the resident was a high fall risk and required hands-on assistance to move from place to place. The Care Plan focus dated 10/22/24 directed staff to use a mechanical aid for transfers. On 7/11/24 at 12:27 PM, the interim Director of Nursing (DON) stated when anyone is manually transferring a resident, a gait belt is to be used unless medically ordered otherwise. A document titled Transfer Technique dated 1/13 indicated the purpose was to safely transfer a resident/patient while minimizing the risk of injury to the resident/patient and caregiver and was resident/patient specific. It directed staff to review any special precautions or approaches to take when transferring a resident/patient and to obtain assistance as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Crest Haven Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471 Based on clinical record review, observations, staff interview, and policy review the facility failed to follow infection prevention standards during incontinence cares for 2 of 2 residents review for incontinence cares (Residents #6, #12). The facility reported a census of 30 residents. Findings include: 1. The Minimum Data Set (MDS) assessment of Resident #6 dated 6/5/24 reflected the resident to have short term and long term memory problems. The MDS revealed the resident totally dependent on toileting and personal hygiene. The MDS reflected the resident always frequently incontinent of urine and not rated for bowel incontinent. The Care Plan, last reviewed 6/3/24, identified the resident to be incontinent of bladder. The Care Plan directed staff to provide incontinence care after each incontinent episode. The Care Plan did not state bowel incontinence. On 7/9/24 at 1:28 PM, Staff L, Certified Nurse Aide (CNA) entered resident #6 room. Resident #6 in wheelchair. Staff M, Certified Nurse Aide (CNA), brought the mechanical lift in room to assist resident and Staff L, CNA. Staff did not complete handwashing or hand hygiene. Staff provided privacy and stated to resident, assist with transfer and incontinent care. Staff hooked sling to equipment, transferred to bed, unhooked sling, equipment placed by door. Staff gathered items for incontinent care. Staff L stated task steps to resident. Staff remove pants, unfastened incontinent product. Staff L gathered wipe from Staff M, wiped front to back the outer labia, disposed the soiled wipe, gathered wipe from Staff M, wiped front to back the outer labia, disposed soiled wipe, with assistance from Staff M, Staff rolled resident to her right side toward the wall, Staff tucked the mechanical lift sling under resident, Staff M held onto resident, Staff L took soiled incontinent product and wipe bowel movement from anus, disposed soiled incontinent product, Staff L gathered wipe from Staff M, wiped perineum, anus, sacrum, disposed wipe, gathered wipe from Staff M wiped perineum, anus, sacrum, disposed wipe, gathered new incontinent product and placed under resident buttocks, Staff L tucked incontinent product fastener under right buttock, Staff rolled resident to her left onto her back, Staff rolled resident to her left side, Staff removed the mechanical lift sling, Staff L adjusted the incontinent product fastener, Staff assisted resident to her back. Staff L closed and fastened incontinent product. Staff L removed soiled gloves, Staff L completed hand hygiene. Staff assisted resident to comfortable position, covered resident, placed call light within reach, placed floor mat at bed side, lowered bed to appropriate level. Staff L completed hand washing, Staff M took soiled bag and mechanical lift equipment to hallway, Staff M placed mechanical lift equipment against the wall, Staff M put soiled bag in soiled utility room, another staff member took the mechanical lift, mechanical lift was not disinfected. Staff M went back to resident's room, performed hand washing, Staff shut off light and exited room. During cares, staff failed to change gloves and wash/sanitize hands when going from dirty to clean. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 3:01 PM the Director of Nursing (DON) stated the staff should perform hand washing or hand hygiene before and after incontinent care, when soiled, and when gloves are removed. Stated the staff should change gloves before and after cares, during cares when soiled. Mechanical lift equipment should be cleaned per policy, routine cleaning. The facility policy titled Perineal Care revised 4/13 included the following documentation: -Separate the labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. -Remove gloves, wash hands, and apply clean gloves if original gloves were visibly soiled. -Clean, rinse, and dry the anal area, starting at the posterior vaginal opening and wiping from front to back. -Remove gloves, wash hands, and apply clean gloves. 2. The MDS assessment dated [DATE] for Resident #12 identified a BIMS score of 4 which indicates severe cognitive impairment. The MDS revealed the resident totally dependent upon staff for all cares with exception of eating. The MDS documented diagnoses that included: unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, non-Alzheimer's dementia, seizure disorder or epilepsy, anxiety disorder, schizophrenia, and dysphagia. The Care Plan revised 2/13/24 identified the resident to be incontinent of bladder and bowel. The Care Plan directed staff to provide incontinence care after each incontinent episode of bladder. The Care Plan directed staff to take resident to toilet at same time each day resident usually has bowel movement. On 7/09/24 at 1:15 PM Staff L, CNA assisted resident #12 to his room. Staff K, CNA assisted Staff L, CNA. Staff gathered mechanical lift equipment, instructed resident of the task, permission granted, staff completed hand washing, staff hooked up mechanical lift to sling, Staff L controlled the mechanical lift equipment, Staff K guided resident to bed, resident positioned over bed, Staff L lowered resident onto the bed. Staff unhooked the sling from the lift. Staff moved the mechanical lift away from the bed. Staff gathered items for incontinent care. Staff L stated task steps to resident. Staff remove pants, unfastened incontinent product. Staff L gathered wipe from Staff K, wiped right groin then left groin, disposed the soiled wipe, gathered wipe from Staff K, Staff L wiped left groin, disposed soiled wipe, with assistance from Staff K, Staff rolled resident to his right side toward the wall, Staff tucked the mechanical lift sling under resident, Staff K held onto resident, Staff L disposed soiled incontinent product, Staff L gathered wipe from Staff K, wiped perineum, anus, sacrum, disposed wipe, gathered wipe from Staff K wiped perineum, anus, sacrum, disposed wipe, gathered new incontinent product and placed under resident buttocks, Staff rolled resident to his left onto his back, Staff rolled resident to his left side, Staff removed the mechanical lift sling, Staff L adjusted the incontinent product, Staff assisted resident to his back. Staff L closed and fastened incontinent product. Staff L removed soiled gloves, Staff completed hand washing. Staff assisted resident to comfortable position, covered resident, placed call light within reach, lowered bed to appropriate level. Staff removed soiled bag. During cares, staff failed to change gloves and wash/sanitize hands when going from dirty to clean and failed to disinfect the mechanical lift. (continued on next page)

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