STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165287	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Specialty Care	451 West Orange Street West Branch, IA 52358

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 0684 Level of Harm - 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** 26529 Based on staff interview, clinical record review, and facility document review, the facility failed to accurately assess resident conditions and implement appropriate interventions in a timely manner for 2 of 9 residents reviewed for accurate assessment. The facility failed to adequately assess and document a resident's worsening gastrointestinal illness symptoms that included stomach ache, abdominal tenderness and emesis that occurred over a 4 day period, failed to notify the medical provider of that resident's symptoms and seek treatment orders for 4 days, the resident required emergent medical treatment in the hospital emergency room (ER) and died within 6 hours of ER admission (Resident #10), failed to accurately assess and document a resident's worsening edema (swelling caused by fluid retention) and inability to urinate for 2 days that required hospitalization (Resident #8), and failed to correctly transcribe a physician's order for insulin for 1 of 3 residents reviewed (Resident #11) for following physician's orders. That failure resulted in missed insulin doses and the resident's hospitalization for Diabetic Ketoacidosis. The facility reported a census of 61 residents. Findings include: 1. The Admission MDS assessment dated [DATE] revealed Resident #10 had diagnoses that included traumatic brain injury, left sided hemiplegia (paralysis on 1 side of the body), diabetes, gastroesophageal reflux, anxiety and bipolar depression, scored 9 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated moderate cognitive impairment, without symptoms of delirium present. The resident had clear speech, no hearing deficits, sometimes was able to make himself understood and sometimes was able to understand others, and able to ambulate and toilet himself independently. The resident had a Power of Attorney (POA) for decision making and responsible for directing the resident's care as needed. Physician orders directed staff to administer the following medications: Tums Chewable 500 mg tablets, 2 tablets oral every 4 hours as needed for stomach upset (start date of [DATE]). Metformin (an antidiabetic medication) 1000 mg administered oral daily (start date of [DATE]). Jardiance (an antidiabetic medication) 10 mg administered oral daily (start date of [DATE]). A Focus area for Diabetes initiated [DATE] on the resident's Nursing Care Plan directed staff: (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 0684 Level of Harm - Actual harm Residents Affected - Few	a. Diabetes medication as ordered by doctor. Monitor for and document side effects and effectiveness. Date Initiated: [DATE] b. Encourage resident to practice good general health practices: lose weight if overweight, stop smoking, compliance with dietary restrictions, compliance with treatment regimen, adequate sleep and exercise, good hygiene and oral care. Date Initiated: [DATE] c. Fasting Serum Blood Sugar as ordered by doctor. Date Initiated: [DATE] The facility's Change of Condition policy, dated as last reviewed in February, 2021, directed staff: 1. Promptly notify the resident or their responsible party, and attending physician of changes in the resident's physical or mental condition or status. 2. Notify the physician when there is a significant change in the resident's condition. Significant change described as a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status; c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. Nursing Progress Notes revealed the following entries: [DATE] at 9:22 p.m. Staff F, RN, stated: Resident complained of stomach ache this shift. Sprite given to him he then requested Tylenol. Tylenol provided resident refused to eat dinner, then continued to sit in his room and pull call light excessively each time staff went in room it was for miscellaneous things not related to stomach ache. This nurse assessed resident, abdomen soft non tender non distended bowel sounds active in all quadrants resident stated last bowel movement (BM) was this morning. This nurse asked resident to describe stomach ache resident stated he was nauseous. This nurse educated resident about eating an actual meal and reduce his soda and cookie intake. Resident verbalized understanding and within a few minutes later resident pulled call light for soda and oatmeal cream pie. Resident continued to pull call light every couple minutes this nurse asked resident if he wanted to be sent to the hospital resident declined. Resident continues to pull call light excessively. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] at 3:56 a.m. Staff G, RN, stated: Resident has been consistently pulling call light back to back within seconds or minutes of each other throughout this shift for miscellaneous things, blanket adjustments, for snacks, help adjusting the pillow, complains of stomach ache - vital signs stable, temperature 97.8, oxygen via nasal canula with saturation of 92%, respirations 18, pulse 92 regular, blood pressure ,d+[DATE], bowel sounds active in 4 quadrants, resident reports last BM ,d+[DATE] in AM, resident reports passing flatus, abdomen nondistended, soft, resident reports tenderness in center of quadrants with palpation - no mass felt. resident educated on better food choices as resident historically drinks several sodas a day back to back and eating junk snacks throughout the day as well. The residents clinical record lacked documentation of resident's condition on [DATE]. [DATE] at 9:45 a.m. Staff H, LPN, stated: Staff reported resident has been vomiting all weekend and hasn't been eating. Resident is pale with dark circles around his eyes. Vitals were taken and recorded and are within normal limits. Resident reported no discomfort, chest pain or shortness of breath. Resident did not eat breakfast today. Lungs clear upon auscultation. Last BM was [DATE] and was large in size. Spoke with Nurse Practitioner at 9:45 a.m , orders for Zofran 8 mg every 8 hours as needed for vomiting and a CBC (complete blood count) with differential and CMP (comprehensive medical provide) laboratory tests ordered for [DATE]. Resident to be sent to the hospital if keeps vomiting and not taking fluids for dehydration. [DATE] at 10:59 a.m., Staff H, LPN stated: Staff reported to this nurse resident was becoming confused and had complaints of shortness of breath. Oxygen saturation was 95% room air and resident had complaints of shortness of breath, called Nurse Practitioner at 10:28 a.m., asked if resident could be sent out , the Nurse Practitioner approved the order, called non-emergent transport at 10:50 a.m., ambulance arrived at 11:09 a.m. The ER Physician Progress Note dated [DATE] described upon their arrival at the facility, the ambulance staff found resident in acute hypoxic respiratory failure that required 6 liters of oxygen per minute, hypotensive (low blood pressure) with systolic pressure (the higher of the 2 numbers recorded for blood pressure results) of 80. The resident was cool to touch and ambulance crew unable to palpate pulses. Norepinephrine (a sympathomimetic drug used to treat critically low blood pressure) administered intravenously (IV) started, the staff unable to obtain a blood pressure after the medication started, and 250 milliliters of IV fluid administered prior to the resident's arrival in the ER. Once in the ER, the resident continued with acute respiratory failure symptoms, required aggressive treatment that included intubation (large tube inserted through the mouth, placed into the lungs and used for mechanical ventilation), a large amount of vomitus occurred during the procedure, another tube then inserted through the nose and into the stomach, attached to suction with immediate returns of 3 liters (approximately 1 gallon) of dark brown liquid (symptom of a bowel obstruction), bowel obstruction confirmed by a CT (computed topography) scan of the stomach and aspiration pneumonia (occurred during intubation with vomitus) confirmed by CT scan of chest. The resident's oxygen saturation level did not increase above the low 70 percent range (normal 97 to 100 percent) despite aggressive efforts, several medications were administered without success to improve the resident's blood pressure, the resident treated unsuccessfully with cardiopulmonary resuscitation (CPR) for circulatory and respiratory failure, and acute respiratory distress syndrome (ARDS), small bowel obstruction, acute kidney injury from dehydration and acute pancreatitis diagnosed at the time of the resident's death on [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Staff interviews revealed: [DATE] at 2:39 p.m., Staff L, RN, stated she worked the evening shift on [DATE] (2 p.m. to 10 p.m.), at first the resident asked for a Coke, she told him he had just had 3, then the resident said he had a stomach ache, she told him the Coke wouldn't help, it was getting close to supper time, he'd just ate 6 oatmeal cream pie cookies. She told him to eat a regular meal at supper, the resident had ate 1 or 2 bites of supper and asked again for a Coke, then asked for another oatmeal cream pie cookie. The resident went to bed shortly after that, put the call light on and wanted Tylenol for a stomach ache, located by his navel. The resident denied nausea, she assessed his abdomen, it was soft, he reported his last BM 2 days earlier, rated the pain at a 1 on a 0 to 10 pain scale, with 10 assigned to the worst pain, she didn't want to give him Tylenol because he hadn't really ate anything for supper. She asked him if he wanted to be sent out (sent to the ER) the resident didn't want to go, and she documented he refused to be sent out. She did not notify his POA about his condition, or consult with his Physician or Nurse Practitioner. When she checked on him later in the shift he said he felt better. [DATE] at 5:17 p.m., Staff M, RN, stated she worked the night shift (10 p.m. to 6 a.m.) starting on [DATE]. the resident had complained of a stomach ache, nothing serious, he is known to eat a lot of junk food and soda, he didn't complain of nausea and didn't throw up on that shift. She then worked a double shift starting at 6 a.m. on [DATE], to 10 p.m. that day, staff reported the resident had an emesis on the day shift, she didn't know if the resident had ate any meals that day or his food intake, and didn't believe the resident had any symptoms that required further assessment or intervention. [DATE] at 5:08 p.m., Staff K, RN, stated she worked from 6 p.m. on [DATE] to 6 a.m. on [DATE], and again at 6 p.m. on [DATE] to 6 a.m. the following morning, she checked on the resident on rounds a few times, he was asleep most of the night, used the call light a couple of times and wanted the aides (Certified Nursing Assistant's or CNA's). [DATE] at 11:40 a.m., Staff I, CNA, stated she worked the day shift on [DATE], around 6:30 a.m., the resident had thrown up, she got him cleaned up, told the nurse, Staff M, RN. The resident went to breakfast, then napped. The resident ate lunch, and wasn't aware of any more emesis on [DATE]. When she worked the day shift on [DATE], they said in report that he didn't feel good and the resident didn't seem like himself. He'd thrown up before breakfast that morning but was still talking, she told the nurse, Staff H, LPN, to look at him. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] at 7:39 p.m., Staff H, LPN, stated she worked the day shift (6 a.m. to 2 p.m.) on [DATE], there wasn't any information related to anything abnormal about Resident #10 passed along in the nurse to nurse shift report that morning, and Staff I, Certified Nursing Assistant's (CNA), told her to look at him, he'd been vomiting for 2 days. The resident was seated in the [NAME] hall common area, he was extremely pale, area around his eyes looked black, the resident said he'd been vomiting. Staff informed her he had only been eating oatmeal cream pie cookies and pop, and not eating food. She took his vital signs, they were normal, and as she assessed the resident he vomited a moderate amount of dark brown liquid. The resident didn't complain of pain at the time, she kept an eye on him, he didn't look right, she called the Nurse Practitioner who gave orders for Zofran, lab work orders for the following day, and to sent him out if he couldn't keep food and fluid down. Within a short time, less than 20 minutes, he looked worse, she called the Nurse Practitioner again and obtained an order to send the resident to the hospital ER. She contacted and informed the DON, Staff J, and the DON told her she was upset about this because she had directed other nursing staff to notify the Nurse Practitioner of the resident's symptoms and obtain orders. After she called for an ambulance and within the time it took to print the paperwork for his transfer, the resident's condition had worsened and he was struggling to breathe. The ambulance staff arrived around the same time and they said he looks terrible. [DATE] at 11:58 a.m. Staff J, RN and current DON, stated she was in the facility on [DATE] and had directed Staff L, RN, to notify the Nurse Practitioner of the resident's condition that day, and expected nursing staff to assess resident's when they had changes in condition, notify the Physicians or Nurse Practitioners and responsible resident party's as appropriate, seek treatment orders when needed, and also notify her of resident condition changes. 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 admitted to the facility on [DATE] with diagnoses that included congestive heart failure, peripheral vascular disease, hypertension (high blood pressure), diabetes and renal insufficiency and bilateral leg amputations below the knee. The Nursing Admission Assessment form completed [DATE] revealed the resident had edema (swelling of the body caused by retained fluid), without further description of location or amount, and continent of urine. The Hospital Discharge Summary dated [DATE] revealed the resident recently hospitalized for hematuria (blood in the urine) that required transfusion with 2 units of blood, a high grade urothelial cancer (involving the urethra) suspected, currently hospitalized for diarrhea with abdominal cramps, and to discharge to a nursing home with medication orders that included: 1. Amiodorone (an anti-arrhythmic heart medication) 200 milligrams (mg) administered oral daily. 2. Torsamide (a diuretic medication) 20 mg administered oral daily. 3. Spironolactone (a diuretic medication) 12.5 mg administered oral daily. 4. Metoprolol Succinate (an anti-hypertension medication) Extended Release (ER) 25 mg administered oral daily. 5. Trospium Chloride (an antispasmodic medication for the bladder) 20 mg administered oral daily. Pharmacy records revealed revealed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The identified medications were delivered to the facility on [DATE]. On [DATE] the pharmacy delivered the same medications to the facility again. The February, 2024 Medication Administration Record (MAR) revealed the resident did not receive the Amiodorone until [DATE], and did not receive the other identified medications until [DATE]. During an interview on [DATE] at 2:11 p.m., the facility's Corporate Nurse stated the pharmacy had used the resident's Hospital Discharge Summary for a medication list, sent those medications to the facility on [DATE] with documented delivery, and staff should have been able to administer those medications on [DATE]. The problem was the former Director of Nursing (Staff B, RN) admitted the resident on [DATE] but didn't complete the admission assessment or enter the medication orders in the computer until [DATE], that should have been completed the day before and the nursing staff would have had the directives for administration on the resident's Medication Administration Record if the process was completed when it should have been. The Corporate Nurse stated nursing staff should accurately and adequately document abnormal resident assessments, and the nursing staff that couldn't find the resident's medication should have checked in the Medication Room, if not there she could have asked the other nurse on duty for assistance, or contacted a manager on call, and most of the resident's ordered medications were in the facility's Emergency Medication Kit and she could have administered medications from that supply if she could not locate the medications, there was no reasonable excuse for the nurse not to administer the resident's medications that day. The Admission Assessment documents completed [DATE] at 11:26 a.m. by Staff B, Registered Nurse (RN) and the former Director of Nursing (DON) described the resident had edema (swelling caused by fluid retention), without description of the amount or location, the resident continent of urine, without further description of deficits or difficulties, and the resident did not have any pain. An Activity of Daily Living (ADL) Assistance problem initiated [DATE] on the Nursing Care Plan directed staff: Toileting - 2 staff assist required, urinal at bedside. Transfer - 2 staff assist required, with Hoyer mechanical lift. The ER Physician Progress Note dated [DATE] revealed the resident presented due to inability to urinate caused by retraction of the glans penis into the shaft, treated for a urinary tract infection and urine outflow obstruction due to glans penis inversion and exacerbation of chronic kidney disease, the resident able to retract and manipulate the penis foreskin to aid with urination, and instructed to do that to allow urine to exit and prevent backflow into the foreskin. A follow-up urology appointment was scheduled for [DATE] and a follow-up cardiology appointment was scheduled for [DATE], and prescription given for Amiodorone 200 mg administered oral daily. Nursing Progress Notes revealed the following entries: A Nursing Progress Note dated [DATE] at 2:30 p.m. transcribed by Staff B, RN stated: Received a phone call from resident's family member stating that resident was requesting to go back to the hospital due to his increased discomfort and bladder pain. Resident transferred to the hospital emergency room (ER) via ambulance. (No documentation of assessment transcribed by the nurse). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] at 9:34 a.m. Staff D, LPN, documented: Attempted to call pharmacy to receive medications for resident due to medications not in medication cart. On call pharmacist resistant on sending medications and questioned nurse where medications went. Contacted DON, informed her of situation, she stated she would contact the on call pharmacist. DON called this nurse back and stated the pharmacy is sending resident's medications this morning. A physician order dated [DATE] directed staff to elevate the resident's scrotum with a rolled towel due to edema. The resident's clinical record lacked any documentation of assessments of the resident's edema, pain, or difficulty with urination, until the following Nursing Progress Note entry: [DATE] at 2:15 a.m. Staff E, RN, documented: Resident assisted to commode around 1:30 a.m. Only able to urinate very small amount, less than 25 milliliters (approximately 5 teaspoons) of thick, cloudy, yellow fluid. Complains of pain to abdominal area rated at 10 out of 10 on pain scale, and that it is more swollen than previous days. Painful upon palpation. This nurse attempted to pull foreskin back, but it is too swollen. Resident reports he can barely eat or drink because he is too uncomfortable and wants to be seen at hospital. Notified on-call provider, order to send to ER, 911 called for transport. An ER to Hospital Admission Physician Progress Note dated [DATE] described the resident presented after unable to urinate for 2 days, treatment required included urinary catheterization by a Urologist physician, and the resident hospitalized with diagnoses that included urinary retention with suspected bladder malignancy, urinary tract infection, acute kidney injury and acute on chronic systolic heart failure. 48888 3. The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating intact cognition. Resident #11 received insulin injections on 7 days of the reference period. Diagnoses included Diabetes Mellitus, cancer, and liver transplant status. MDS indicated a life expectancy of less than 6 months with hospice services. The Care Plan, revised on [DATE], lacked focused area for insulin administration, blood sugar monitoring, or signs and symptoms of high or low blood sugars for Resident #11's diagnosis of Diabetes Mellitus. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated [DATE], lacked scheduled insulin order in place between the dates of [DATE] and [DATE] and lacked scheduled blood sugar checks between the dates of [DATE] and [DATE]. The [DATE] MAR and TAR included the following orders: -Lantus (insulin glargine) solution 100 units per milliliter(ml). Inject 4 units subcutaneously two times a day related to Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Started on [DATE] and discontinued on [DATE]. -Lantus (insulin glargine) solution 100 units/ml. Inject 4 units subcutaneously one time a day for Diabetes. Started on [DATE] and discontinued on [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Novolog (insulin aspart) Solution subcutaneous injection with meals related to Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease following blood sugar sliding scale: if blood sugar between ,d+[DATE] give 1 unit, ,d+[DATE]= 2 units, ,d+[DATE]= 3 units, ,d+[DATE]= 4 units, ,d+[DATE]= 5 units. Blood sugar greater than 400, notify the provider. Started on [DATE], discontinued on [DATE], and restarted on [DATE]. -Blood sugar checks before meals related to Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Started on [DATE] and discontinued on [DATE]. -Blood sugar checks once a week every Monday related Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Held between the dates of [DATE] through [DATE] and revealed a start date for [DATE]. Review of the Nursing Progress Notes between the dates of: [DATE] through [DATE] revealed the following entries: 1. On [DATE] at 04:32 AM, Resident #11 observed to be pale, clammy, and difficult to arouse. Blood sugar recorded as 37. Hospice notified, facility received verbal orders to administer Glucagon 1 milligram(mg) per vial, discontinue the evening dose of Lantus (insulin glargine), discontinue the sliding scale Novolog (insulin aspart), and perform blood sugar check once per week. Nursing documented administration of Glucagon 1 mg at 04:40 AM. 2. On [DATE] at 05:28 AM: Nursing documentation for follow up blood sugar of 78. 3. On [DATE] at 09:45 AM: Note indicated Resident #11's insulin and blood sugar checks had been discontinued the previous day and reported no noted symptoms of hypoglycemia (low blood sugar). 4. On [DATE] at 05:48 PM: A change in condition assessment completed for altered mental status and other change in condition. Assessment revealed an altered level of consciousness, more assistance with activities of daily living required, general weakness, and decreased mobility. Change of condition assessment also informed there had been a change in medications. 5. On [DATE] at 05:48 PM: Family notification of Resident #11's condition change with documentation that the family had been upset about discontinued insulin and blood sugar checks. Facility also notified Hospice of Resident #11 condition change and blood sugar reading message of HIGH (HI). Orders received from Hospice for an as needed Novolog (insulin aspart) solution, following previous sliding scale order and Lantus (insulin glargine), 4 units in the morning. Nurse documented 5 units of Novolog given following as needed sliding scale order. 6. On [DATE] at 06:09 PM: Blood sugar continued to read as HIGH (HI), Hospice notified. 7. On [DATE] at 06:10 PM: Resident #11 lethargic with pale, clammy skin, and fruity smelling breath. Facility notified family and discussed the insulin changes that occurred on [DATE], family stated they thought Resident #11 would continue to receive a morning dose of insulin and blood sugars would be checked if a change in condition occurred. Hospice provider notified and advised that the morning dose of Lantus (insulin glargine) is to continue. Blood sugar continued to read HIGH (HI) after the 5 units of Novolog (insulin aspart) administered. Facility received verbal order to immediately transport Resident #11 to the Hospital for possible Diabetic Ketoacidosis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	8. On [DATE] at 02:00 AM: The Hospital informed facility that Resident #11 would be admitted for Diabetic Ketoacidosis. The Incident Report, dated [DATE], completed by Director of Nursing (DON), revealed that during review it is noted that order received was to discontinue the evening dose of Lantus (insulin glargine) but both morning and evening doses were discontinued. Resident #11 sent to the emergency room as an immediate action taken. Additionally the DON contacted Nurse who took orders on [DATE] and provided education. The facility self-reported incident to the Department of Inspections, Appeals, and Licensing. A statement, signed and dated [DATE] by Staff A, Licensed Practical Nurse (LPN), revealed orders received from Hospice provider to discontinue evening dose of Lantus (insulin glargine), discontinue sliding scale insulin, and check blood sugar once per week. Staff A informed that Resident #11's blood sugar rechecked and read a higher result that was within normal limits. The facility provided document, titled Past Non-Compliance Checklist, dated [DATE], revealed the following corrective actions taken for the resident (Resident #11) affected by incident: Past non-compliance completed to include diabetic management, hospice orders, review of the shift to shift report, review of the 24 hour report, and review of the order listing report. All telephone orders must be printed off for a second nurse to validate the accuracy of new orders daily Monitoring of compliance during morning clinical meetings. Ongoing monitoring of compliance with Quality Assurance and Performance Improvement (QAPI).