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	11/21/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48452 Based on clinical record review, facility notification documents, and staff interviews the facility failed to notify the Office of the State Long-Term Ombudsman (OSLTO) of two separate resident transfers to the hospital for 1 of 3 residents reviewed for hospitalization s (Resident #2). The facility reported a census of 54 residents. Findings include: The Minimum Data Set (MDS) for Resident #2 dated 4/30/24 documented the resident had a Brief Interview for Mental Status) of 13 of 15 which indicated intact cognition. The MDS list of diagnoses included cancer, schizophrenia, and excoriation (skin picking) disorder. The Care Plan initiated 4/25/24, revealed the resident had Focus areas to address impaired cognitive function, risk for skin and soft tissue infection, required mental health support for anti-depressants, anti-anxiety medications, and anti-psychotics, and had diabetic ulcers on 8 fingers. Clinical record review revealed Resident #2 transferred to the hospital on the following dates: 05/20/24, 06/03/24, 08/29/24, and 10/30/24 The facility provided Notice of Transfer Forms for May, June, August, and October 2024. The Notice did not included Resident #2 for the May and June transfers to the hospital. During an interview on 11/21/24 at 09:26 AM, the Administrator stated the facility social worker was responsible for submitting all discharges monthly to the OSLTO. When asked how it was decided if a transfer to the hospital should be submitted, the Administrator stated it depended on if the transfer was overnight. She acknowledged one of the missing transfers included a same day return and the other was a 5 day hospital visit. During an interview on 11/21/24 at 12:21 PM, the Social Services Director stated she reviewed the electronic health record every morning she was in the building for discharges. When asked how she decided if a resident's transfer should be included on the ombudsman report, she stated she did not include them if they returned the same day.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on observation, clinical record review, policy review and staff interview the facility failed to prevent the recurrence of a pressure ulcer for 1 of 2 residents reviewed (Resident #27). The facility reported a census of 54 residents. Findings include: The State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities, revised 8/08/24, provided the following information on the staging of pressure ulcers: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue pressure injury. Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis (middle layer of skin) Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat (soft fat that is located just beneath the skin and can be pinched) may be visible in the ulcer and granulation tissue (new tissue, sign of healing) and epibole (curled or rolled wound edges) are often present. Slough (yellowish/white material in a wound bed) and/or eschar (dead tissue, dark in color) may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole, undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. The Minimum Data Set (MDS) assessment dated [DATE], for Resident #27 revealed a Brief Interview for Mental Status (BIMS) score of 99 out of 15, which indicated a severe cognitive impairment. The MDS list of diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, and bullous pemphigoid (an autoimmune disorder causing raised blisters on the skin). The MDS indicated Resident #27 as dependent on staff for dressing her lower body and putting on/taking off footwear. The Braden Scale for Predicting Pressure Sores Risk assessment dated [DATE], resulted in a score of 14 out of 18. Per the document scoring key, a score of 13 to 14 indicated a moderate risk for a pressure injury. The Braden Scale assessment dated [DATE], resulted in a score of 10 out of 18. A score of 10-12, per the scoring key, indicated a high risk of pressure injuries. The Care Plan, initiated on 10/21/24, included a Focus area to address I have impairment to my skin. The Interventions, in part, included; Bilateral prafo (Protective Relief Ankle Foot Orthosis (medical device, such as brace or splint) boots to feet, initiated on 8/30/24. on Resident #27's feet. The Visual/Beside Kardex Report (name of a documentation system) as of 11/21/24, Dressing section directed the use of Bilateral prafo boots to feet. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Wound Evaluation & Management Summary Note, from the wound provider for Resident #24, dated 9/23/24, revealed Stage 4 pressure wound to the left heal (resolved on 9/23/24). Recommendations: Off-Load wound; reposition per facility protocol; Recommend no shoes. Please use non-skid socks. The Physician Progress Note dated 10/24/24, documented Wound, Date identified: 10/14/24; Location: L (left) heel; Type of wound: Pressure; Measurement/Size: 3.24 x 1.87 x 2.11 (measured in centimeters). Plan: Pressure injury to left heel, stage 2. Previous stage 4 ulcer in this site. It had resolved 9/23/24. New stage 2 in this area. Skin prep twice daily. Apply Profo boots while in wheelchair and in bed. Signed [name redacted] FNP (Family Nurse Practitioner) on [DATE] at 2:49 PM. The Physician Progress Note dated 10/31/24, History of Present Illness: She presents to be seen for L heel wound. She recently was treated for a stage 4 ulcer on this heel that had been resolved 9/23 [2024] but another one has begun. It appears she is getting wounds from pressure in her wheelchair and/or bed. Today it was evaluated and has decompensated. The note documented, in part; Location: L heel Type of wound: pressure ulcer; Measurement/Size: 2.34x1.72x1.74 (measured in centimeters); Progress: Worsening. Plan: Pressure injury to deep tissue of left heel. Apply skin prep to L heel wound twice daily. Use Profo boots at all times (in and out of bed). Signed [name redacted] on [DATE] at 12:54 PM. A review of Physician Orders revealed an order dated 11/4/24 for Heel protectors to bilateral heels at all times. The Wound Evaluation dated 11/19/24, completed by conducted Staff A, Licensed Practical Nurse (LPN) documented the wound measured 1.97 cm x 1.07cm x 2.31cm. During an observation on 11/19/24 at 12:27 PM, Resident #27 sat in her wheelchair, while eating lunch with assistance from staff. The resident wore a tennis shoe on her right foot. The left foot unable to be visualized as covered with a blanket. During an interview on 11/19/24 at 11:42 AM, Staff A, LPN explained when she went in the resident's room this morning to check the wound she took off a tennis shoe on the resident's left foot as she felt it was too tight and probably exacerbating the problem. Staff A stated the left heel was clear new skin back in September and now was back to measuring as a wound. She felt it just kept coming back. During an interview on 11/19/24 at 1:44 PM, Staff B, Certified Nursing Assistant (CNA) explained she got Resident #27 up for the morning. She made sure the peri area was clean and then put the resident's pants on and transferred her to the wheelchair. She then put both tennis shoes on the resident. She noted she was a bit confused about the shoes as she had heard different things as to when the resident was supposed to wear them. She knew Resident #27 always wore the protective boots at night but wasn't sure about when she was in the wheelchair. She admitted to forgetting to put on another piece of protective equipment as well. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/19/24 at 2:11 PM, the Family Nurse Practitioner (FNP) explained she expected the resident to wear Prafo boots on both feet at all times. She noted the resident was usually in her socks as she doesn't walk. The FNP expressed the recurrence of the pressure ulcer could have been prevented. It The left heel was fully healed in September. She could not say for certain that wearing shoes would cause it to come back; more than anything when the resident not having anything on her feet to protect them was when it comes back. However, it was fully healed and recurred. During an interview on 11/21/24 at 10:04 AM, the Director of Nursing (DON) explained Resident #27 is supposed to wear bilateral heel protectors at all times. She acknowledged she was not aware staff had placed tennis shoes on the resident. She recognized the first pressure ulcer had healed, and they were currently in the process of healing the recurrent one. A facility policy, revised October 2020, titled Wound Care, 10/2010 Purpose statement declared The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The Preparation section instructed staff, in part to; a. Verify there is a physician's order b. Review the resident's care plan to assess for any special needs of the resident.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on observations, resident and staff interviews, and facility policy review the facility failed to respond to call lights within 15 minutes for 4 of 4 residents reviewed (Res #6, #12, #50, #204) and the facility failed to staff according to the Facility Assessment for seven out of eleven days reviewed. The facility reported a census of 54 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE], included a Brief Interview for Mental Status (BIMS) for Resident #12. The BIMS resulted in a score of 14 out of 15 which indicated intact cognition. The MDS list of diagnoses included amputation, non-Alzheimer's dementia, and stroke. The MDS indicated the resident as dependent on staff to roll left and right, sit to lying, lying to sitting on side of the bed, chair/bed-to-chair transfer, and transfer to toilet toileting needs. During a continuous observation on 11/19/24 starting at 12:50 PM, Resident #12's turned on his call light. Staff A, Licensed Practical Nurse (LPN) turned off the call light and administered his insulin. Personal cares were not provided at that time. The resident called out he needed to go to the bathroom after the LPN left. Staff B, Certified Nursing Aide (CNA) arrived at 1:08 PM to toilet the resident. 2. The MDS dated [DATE], for Resident #204 documented a BIMS score of 15 out of 15 which indicated intact cognition. The MDS list of diagnoses included normal pressure hydrocephalus (fluid on the brain), morbid obesity, and adult failure to thrive. The MDS revealed the resident had not attempted a chair/bed-to chair transfer, or toilet transfer due to a medical condition or safety concerns. The MDS indicated the resident as always incontinent of bladder and bowel. During a continuous observation on 11/20/14 starting at 9:12 AM, Resident #204 turned on her call light. Staff C, LPN checked in with resident at 9:25 AM, turned off the light, and stated she would send helpers down. At 9:27 AM, Staff D, Certified Medication Aide (CMA) administered medications to the resident and did not assist her with personal cares. During an interview at 9:34 AM, Resident #204 stated she continued to wait for assistance. The Activities Coordinator turned the light back on at 9:43 AM for assistance. Two CNA's arrived to assist Resident #204 at 9:45 AM. During an interview on 11/19/24 at 11:17 AM, a resident family member stated the facility does not have enough staff on second shift-they often have only one CNA on each hall and that isn't good for residents who are a 2 assist. Friday, Saturday, and Sunday residents have to eat in their rooms for dinner because they do not have enough staff to transfer them all to the dining room. The family member stated this occurs randomly on average 3-4 nights per month. During an interview with 11/20/24 10:12 AM, Staff E, CNA explained the expectation was for staff to answer call lights in two minutes or less. They turn off the light and can leave and return if the resident needs the staff to get something like water. With personal cares staff are supposed to do that right then and there. If someone needs assist of two she would turn off the call light, get another helper, and come right back to assist. CMA's are allowed to assist if someone has been waiting. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 10:17 AM, Staff F, CNA explained she was told there was a 5, 7, and 15-minute window to answer the call light. Staff F stated the facility being short on staff a lot of time it's not really possible. It can take up to 20-25 minutes before they get to the residents. She felt really bad about it but with being short staffed there's nothing they can do. This happens mainly on the weekend. She thought it was ok for other staff turn the light off and let CNA's know right away that they are needed, but if they are short staffed they will forget to go to the room. They leave the light on in that case. CMA's can help with cares as well if they are at a point to stop. During an interview on 11/20/24 at 10:26 AM, the Director of Nursing (DON) explained she expected call lights to be answered in 15 minutes or less as per state regulations. Staff should not turn off the light and not come back. They need to take care of the call light the first time they are in there. CMA's are able to help. They need to prioritize as they do have that two-hour window to pass medications. 48452 3. The MDS for Resident #6 dated 10/18/24, documented the resident had a BIMS score of 14 out of 15 which indicated intact cognition. The MDS list of diagnoses included atrial fibrillation (irregular heart beat), hallucinations, and diabetes mellitus. The Care Plan, Date Initiated 10/11/2023, included a Focus area to address I am at risk for falls. I do not wait for assistance to transfer. Interventions included, in part; Continue to educate me I am not independent with tranfers, initiated on 7/8/24; Encourage me to use my call light for assistance, initiated on 10/11/23; and I have a sign on my walker reminding me to call for assistance, initiated on 12/6/23. During an interview on 11/18/24 at 11:13 AM, Resident #6 stated the facility could work on answering call lights faster. He reported it took at least 20-30 minutes for lights to be answered. When asked how often that happened, he stated at least every other day and that it happened on all shifts. 4. The MDS for Resident #50 dated 10/10/24, documented the resident had a BIMS score of 14 of 15 which indicated intact cognition. The MDS list of diagnoses included atrial fibrillation, metabolic encephalopathy (chemical imbalance in the blood that affects the brain), and cellulitis (skin infection). The MDS assessed Resident #50 dependent on staff for chair/bed-to-chair transfer, transfer to the toilet, and for personal hygiene. The Care Plan, Date Initiated: 10/21/24 included a Focus area to address I am at risk for falls. Interventions included, in part; Encourage me to use my call light for assistance, initiated on 10/21/24. During an observation on 11/18/24 at 1:15 PM, Resident #50 sat in his wheelchair at the entrance to his room. He shared it took a long time for call lights to be answered here. When asked how long, he stated 20 minutes or more. He reported he knows this because of observation and because the staff tells him. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, revised March 2021, titled Answering the Call Light, Purpose statement declared The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Steps in the Procedure direct staff to: 1. Identify yourself and politely respond to the resident by his/her name . a. If the resident needs assistance, indicate the approximate time it will take for you to respond. b. If the resident's requires requires another staff member, notify the individual c. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance. 2. If assistance is needed when you enter the room, summon help by using the call signal. The policy did not specify a time frame in which calls should be answered. 34821 5. A review of the Daily Staffing Plan in the Facility assessment dated [DATE], identified the need for: a. Two licensed nurses on day, evening & night shift. b. Two medication aids on days c. Six CNAs on the day shift d. Four CNAs on the 2 shift e. Three CNAs on the night shift. The Nursing Daily Assignment sheet dated 10/26/24 (Saturday), listed two nurses, one CMA, and four CNA's for the 0600 -1400 (6:00 AM -2:00 PM) shift. The Nursing Daily Assignment sheet dated 10/27/24 (Sunday), listed two nurses, and three CNA's for the 0600-1400 shift. The Nursing Daily Assignment sheet dated 11/2/24 (Saturday), listed two nurses, two medication Aids and four CNA's for the 0600-1400 shift. The Nursing Daily Assignment sheet dated 11/3/24 (Sunday), listed two nurses and five CNA's for the 0600-1400 shift. The Assignment sheet for the 1200-2200 (2:00 PM to 10:00 PM) shift listed two nurses, one CMA, and two CNA's. The Nursing Daily Assignment sheet dated 11/10/24 (Sunday), listed two nurses, one CMA and four CNA's for the 0600-1400 shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nursing Daily Assignment sheet dated 11/16/24 (Saturday) listed two nurses, one CMA, and five CNA's for the 0600 - 1400 shift. The Nursing Daily Assignment sheets dated 11/20/24 (Wednesday), listed two nurses two CMA's, and 5 CNA's with one CNA on orientation for the 0600 -1400 shift. During an interview on 11/20/24 at 1:41 PM, the DON reported the Assistant Director of Nursing (ADON) completed the schedule. During an interview on 11/21/24 at 9:23 AM, the DON reported the call light system is old and they are unable to produce call light records or logs. The DON and the ADON reported the staffing of 6 CNAs on the day shift each CNA has about 8- 10 residents for each CNA to care for. The DON reported at times she will find the CNA sitting at the nurses' station, when asked what they are doing they tell her they are charting. The DON reported the CNAs will complain that they need more help. She reported they have the number of resident here, some of the resident can do almost everything independently and just need 5 minutes of help each a few times a day. She stated some residents need a little more care and some need a lot of care. She said the CNA job is busy and they should be able to get things done. During an interview on 11/21/24 at 10:28 AM, Staff I, Registered Nurse (RN) reported the facility has good and bad days with staffing. During an interview on 11/21/24 at 1:10 PM, the DON and the ADON reported they struggled with the weekend schedule to get it covered. The DON stated they do the best they can to get it covered and come in themselves to work. They both acknowledged that resident have complained of waiting to long for help. The ADON reported she added her self and the DON to the assignment sheets when they work the floor.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48452 Based on observations, facility policy review and staff interviews the facility failed to use hand hygiene during a noon meal service in an attempt to prevent cross contamination of food. The facility reported a census of 54 residents. Findings include: The following observations occurred during the noon meal service on 11/19/24, starting at 11:46 AM: a. At 12:04 PM, Staff H, [NAME] after taking a pan of food out of the oven, wiped his right hand on the side of his shirt. b. At 12:05 PM, Staff G, [NAME] touched with her left hand while she walked into the dining room. Staff G then pushed a plate service cart into the kitchen. Without washing her hands, Staff G returned to the serving line. While Staff G stirred a mixture of lettuce and cheese, a portion of the mixture spilled out. Staff G caught the spilled mixture with her bare left hand and put it back in to the pan used for preparation. c. At 12:11 PM, Staff G put a serving ladle down, and wiped her left hand on her left knee. She then touched a cart, and without washing her hands returned to plating food. During the service, Staff G picked up resident meal request slips, waded them up and threw them into the garbage. Staff G then put on one glove, picked up a bowl and put in near other dirty items. Staff G took off the glove, and without washing her hands resumed plating and serving food. d. At 12:17 PM, both Staff G and Staff H left the serving area to go to the dining room. Both pushed carts back into the room. Staff G picked up a paper from the floor and put it on the cart. She did not wash her hands. Staff H wiped his fingers on the right side of his shirt and went back to the serving line without washing his hands. During an interview on 11/19/24 at 12:45 PM, the Certified Dietary Manager (CDM) stated she expected staff to wash their hands before they started serving and if they got anything on their hands. When asked about movements through the kitchen and dining room, she stated they should wash them no matter where they move. During an interview on 11/20/24 at 2:55 PM, the CDM confirmed handwashing had been covered in orientation, and infection control covered in on-going training. She stated she had already spoken with the staff and felt they were nervous during the meal service. A facility policy, revised on 3/9/2020, titled Handwashing, Policy statement declared Hands shall be washed in accordance with established procedures in order to prevent contagion and to protect residents from infections. The Procedure, step #2 Hands will be washed directed staff, in part to wash hands when: g. After hand contact with unclean equipment and work surfaces, soiled clothing, and rags. (continued on next page)

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	11/21/2024

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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l. Leaving and returning to the kitchen/prep area. m. Anytime a task is changed.

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49976 Based on facility policy review, and staff interviews the facility failed to have an Infection Preventionist who completed specialized training in infection prevention and control. The facility reported a census of 54 residents. Findings include: During an interview on 11/19/24 at 12:45 PM, the Director of Nursing (DON) and Regional Nurse Consulted stated the facility does not currently have a certified Infection Preventionist (IP). The DON stated the Assistant DON is currently taking the required classes and hopes to be done with the course by the end of the week. During an interview on 11/20/24 at 12:54 PM the DON suggested the IP interview should perhaps be conducted with the regional personnel as she is not certified and new to the position. In a follow-up with the Regional Director of Operations, she stated she was not a nurse and would have to collaborate with the Regional Nurse Consultant and the DON to decide who would be best to completed the interview as no IP is currently on staff. The facility policy, revised September 2017, titled Surveillance for Infections, Policy Statement declared The Infection Preventionist will conduct ongoing surveillance for Healthcare-Acquired Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions.