STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165463	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Nursing & Rehab	2401 South Des Moines Street Webster City, IA 50595

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 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** 46875 Based on clinical record review, hospital clinical record review, hospital images, staff interviews and policy review, the facility failed to identify a resident with pressure ulcers/wounds and assure the resident received treatment and services, consistent with professional standards of practice, to promote healing of ulcers/wounds for 1 of 2 resident reviewed (Resident #1). The facility reported a census of 60 residents. Finding include: The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, with slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue) which may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound. Other staging considerations include: (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: 165463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2025
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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent skin. 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. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severely impaired cognition. The MDS identified Resident #1 required substantial/maximal assistance with rolling left and right in bed and listed them as dependent on staff with transfers. Resident #1's MDS included diagnoses of non-Alzheimer's dementia, malnutrition (inadequate intake of nutrients), depression, arthritis, hyperlipidemia (high cholesterol) and a urinary tract infection (UTI) in the past 30 days. The MDS documented Resident #1 had a risk for developing pressure ulcers/injuries and had one or more unhealed pressure ulcer/injuries. The MDS documented Resident #1 had one unstageable pressure ulcer present on admission or reentry. The MDS documented the following skin and ulcer/injury and treatments: pressure reducing device for chair/bed, nutrition/hydration to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressing and application of ointments/medications. Resident #1's discharge assessment, return not anticipated MDS dated [DATE] documented they didn't have any unhealed pressure ulcer/injuries. The Care Plan Focus revised on 12/26/24 revealed Resident #1 had a potential impairment to their skin integrity related to fragile skin, history of pressure wounds, and current wounds/blisters to bilateral lower extremities.The care plan directed the following Interventions: a. Air overlay - 10/28/24 b. Heel boots at all times - 10/28/28 c. History of deep vein thrombosis (DVT) - 12/26/24 d. History of pressure ulcers from hospital stay - 12/26/24 e. Winged mattress - 10/28/24 f. Incontinent care products will be used after each incontinent episode and prn (as needed). Staff to provide nutritional supplement and protein supplement as needed. Staff to reposition Resident #1 upon arising, before meals, after meals, at hour of sleep and on rounds throughout the night and prn. Pressure relieving device to bed and chair as needed. - 7/30/24 g. Nursing to administer treatments per Physician orders and monitor for effectiveness and adverse drug reactions (ADRs). Staff to report to the Physician and family as needed. 1/4 upper side rails x 2 up as needed on bed to facilitate bed mobility and to aid with transfers. - 7/30/24 (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 0686 Level of Harm - Actual harm Residents Affected - Few	h. Staff to observe Resident #1's skin with AM (morning) and PM (evening) cares and with baths 2 times weekly. Staff to document any abnormal skin findings and report to the Physician and family if indicated. Nursing to administer treatments per Physician orders, observe effectiveness, and adverse drug reactions. Staff to consult with the wound nurse and Dietitian as needed. - 7/30/24 i. Weekly skin assessment completed by a nurse. - 7/30/24 The New Order Note dated 12/17/24 at 12:52 PM reflected the Physician came to the facility and examined Resident #1's left heel. The Physician gave a new order to start cephalexin (oral antibiotic) 500 mg (milligrams) TID (Three times a day) for 7 days. The note indicated Resident #1's wife knew of the new order due to being present during the Physician visit. A Physician Progress note dated 12/17/24 documented Resident #1 had a sore with redness around it on the left side of the posterior heel. The note identified Resident #1 as wheelchair ambulatory and often had his foot on the foot pedal. In addition, Resident #1 had a hospitalization where he spent several days inpatient with pressure on his heels. The note listed Resident #1's wife present at the visit and agreed to start antibiotic therapy with a podiatry consult. The physical exam documented the left heel had a small 0.5 x 0.5 circular area of darkened ulcer or dry scabbed. The note described the area as mildly tender to palpation with the surrounding skin had erythema (redness). The note documented the area appeared superficial with uncertainty of the depth of the ulcer. The note directed staff to start cephalexin 500 mg TID for 7 days, and the Physician would request a podiatry consult. The Skin/Wound Note dated 12/18/24 at 10:52 AM documented all of Resident #1's pressure areas from readmission resolved. Review of the facility form titled Weekly Pressure Ulcer Assessment for the left heel revealed the area resolved on 12/18/24. The Transfer to ER note dated 12/26/24 at 4:36 PM reflected the facility sent Resident #1 to the emergency room (ER) per family request via private vehicle. The Hospital emergency room (ER) note dated 12/26/24 identified Resident #1 arrived at the ER at 6:21 PM. The note documented the hospital admitted Resident #1 for a wound check and for nursing home placement. The Hospital Wound Assessment/Care Records dated 12/26/24 at 11:52 PM documented a pressure injury to Resident #1's left heel present on admission. The Wound Center Nurse assessed the pressure injury to the left heel on 12/27/24. The wound care assessment records and images revealed an unstageable pressure injury to the left heel that measured 0.7 cm (centimeters) (length) x 0.7 cm (depth) x 0.1 cm (width). The peri (around) wound listed as dry and intact. The Hospital Wound Assessment/Care Records dated 12/26/24 at 11:53 PM documented a pressure injury to Resident #1's posterior left knee present on admission. The Wound Center Nurse assessed the pressure injury to the posterior left knee on 12/27/24. The wound care assessment record and image revealed an unstageable pressure injury to the posterior left knee with 100% yellow slough (dead tissue that can be moist, stringy, or sticky to the wound bed) that measured 1.7 cm (length) x 0.7 cm (width) and 0.1 cm (depth). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Hospital Wound Assessment/Care Records and Image dated 12/27/24 documented Resident #1 had a stage three pressure area to the coccyx that measured 1.2 cm (length) x 0.5 cm (width). The assessment list the wound bed as 50% granulation tissue (new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process) and 50% slough. A Hospital Progress Note written by the Wound Center RN (Registered Nurse) dated 12/27/24 at 10:00 AM documented they saw Resident #1 for an initial assessment of his skin. Resident #1 had a stage 3 pressure wound to his coccyx, unstageable pressure wound to his left heel, and unstageable pressure wound to his left posterior knee. Resident #1 had a wound to his left knee and right lower leg from a burn also. These wounds are 100% dry eschar (thick black dead tissue). The Wound Center RN ordered for Resident #1 to wear a mepilex sacrum (foam dressing) over his coccyx area for protection, chair cushion in recliner, low air loss mattress, heels elevated off of all surfaces, and reposition every 2 hours. Review of Resident #1's facility clinical record lacked identification/documentation of the pressure wounds to the left heel, posterior left knee, and the coccyx. On 12/31/24 at 1:15 PM, the Nurse Manager, Licensed Practical Nurse (LPN), stated Resident #1 didn't have any other pressure ulcers/injuries after 12/18/24. She said she followed the left toe and the left heel pressure ulcers from a prior hospitalization and healed the pressure ulcers on 12/18/24. She reported Resident #1 didn't have skin sheets after 12/18/24 because he didn't have anything. On 12/31/24 1:51 PM, Staff D, CNA (Certified Nursing Assistant), stated the last time she gave Resident #1 a bath as 12/26/24 before he left the facility. She stated she had her own bath sheets that she documented baths on, she didn't document in the electronic medical record, that the girls in the neighborhoods document the baths. She stated she also documented the weights on the sheets. She stated she didn't mark any skin areas noted on the residents that she gives a bath too, because the nurses are really good and on it when she reports an area. She stated that he had an area to his left heel. She added she wouldn't describe it or make an assessment on it because that is not her area, but that he did have an area. She doesn't remember if he had an area to his bottom or the back of his left knee. She stated he did wear heel lift boots. On 12/31/24 at 3:55 PM, Staff E, CNA, reported she worked 12/25/24. She didn't recall any new areas for Resident #1. She stated she didn't see anything on his bottom or know of anything on his heel. She stated they kept the left knee wrapped up because of the burns so she didn't see anything. She stated Resident #1 started to retract his left knee around that time. She described it as a little more painful for him when changing him. She reported the retraction to Resident #1's knee as new for him. On 12/31/24 at 4:14 PM, the Nurse Manager reported they resolved Resident #1 left heel on 12/18/24. She stated he had a small scab on the heel, it lifted and revealed the heel as intact. She stated she didn't know anything about pressure areas to Resident #1's back of the left knee or buttocks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/31/24 at 4:17 PM, Staff D reported she saw a little black spot to his left heel and stated she couldn't remember if she told the nurse or not, recalling it could have been a piece of lint. She reported the area to the heel as not new to her because she knew that the nurses treated the left heel. She stated if she saw something out of the normal, she would report it to the nurse, and if she didn't remember the area from before she would report it. She stated Resident #1 sat down in the bathtub, so his feet are hard to see. On 1/6/25 at 8:55 AM, the Nurse Manager reported she completed the treatments to Resident #1 on 12/26/24. She stated she concentrated on the treatment to his left knee. She stated she didn't roll him over to look at the back of the knee, buttocks or heels. She reported she had reviewed the hospital records and she acknowledged the facility didn't have any of those skin areas documented. She stated she thought the left heel received more skin damage. She stated when she did the treatment on 12/26/24 she was in a hurry to get the treatment completed as the wife was present in the room and she was not very nice. She reported the floor nurses are responsible for completing the weekly skin assessments. On 1/6/25 at 12:17 PM, the Wound Center RN acknowledged she evaluated Resident #1 in the hospital on 12/27/24. She stated Resident #1 had a small stage 3 pressure wound to his coccyx. She reported a pressure wound usually started out as a red area or a blister area. She stated she could not see a stage 3 pressure wound appearing overnight. In addition, the Wound Center RN reported Resident #1 had a pressure area to the left heel and a pressure area to the back of the left knee. She stated the left heel had a dry, small dark/reddish area. She stated it was clearly a pressure ulcer due to location, resident history, and the area wasn't a normal skin color. She stated Resident #1's wife reported the facility told her they healed the area to the left heel. She stated behind the left knee the pressure ulcer was 100% yellow slough and hard to measure as the left knee was contracted and couldn't be straightened out. She stated she didn't feel the area behind the knee could develop overnight either. She reported out of all the areas maybe the heel ulcer but that would be a stretch. She stated the left knee contracture and dressing may have contributed to the development of the wound behind the left knee. She stated you don't get a pressure wound from just a dressing unless it was wrapped too tight. On 1/6/24 at 2:28 PM, the Nurse Manager reported if a nurse identified a new pressure area, she expected the nurse to notify her and she would complete the wound assessment and/or measurements. She stated if she was not available then the floor nurse would do it. She reported the floor nurse as responsible for notifying the Physician and family of the new area. She stated they would review the Care Plan and add new interventions depending on what was already in place. A facility policy titled Pressure Injury Prevention and Management dated 2024 documented the facility as committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and service to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 46875 Based on observations, staff interviews, family interview, clinical record review, hospital clinical record review, facility images, hospital images and policy review, the facility staff failed to ensure residents who required assistance to move around couldn't come into direct contact with the electric baseboard heater for 1 of 3 residents (Resident #1) reviewed. Resident #1 required the staff to utilize a mechanical lift to transfer in or out of the bed, needing significant assistance from the staff for all mobility. A staff member found Resident #1 with their legs laying on top of the electric baseboard heater on 12/8/24 at 12:44 AM. Staff interviews revealed Resident #1 potentially laid on the electric baseboard heater for approximately an hour before staff discovered him. When the staff moved Resident #1, they discovered he suffered burns to both legs. An observation of Resident #1's room on 12/30/24 revealed an electric baseboard heater, without a protective device, that had a surface temperature of 124 degrees Fahrenheit (F). Review of the facility staff documentation revealed that all of the rooms in the 100, 200, and 300 hallways had electric baseboard heaters similar to Resident #1's room. The staff documented the electric baseboard heaters had surface temperatures ranging from 124 degrees F to 130 degrees F. An interview with the maintenance staff indicated they believed the electric baseboard heaters could potentially reach a maximum temperature of 180 degrees Fahrenheit. The State Agency informed the facility of the Immediate Jeopardy on 12/31/24 at 1:56 PM that began on 12/8/24. The Facility Staff removed the Immediate Jeopardy on 12/31/24 through the following actions: -Resident #1 immediately positioned away from heater - 12/8/24 -Assessment and First aid initiated, primary care provider (PCP) and wife updated - 12/8/24 -Resident #1's room rearranged with beds moved to wall without a register - 12/8/24 -Bed placement audit performed for all resident beds with electric heaters and any beds with concern were moved to safe distance of 3 feet - 12/9/24 -Safe touch surface audits done on all electric registers - 12/9/24 -Room thermostats to be set no higher than 71-degree F unless management notified - 12/9/24 - Random safe touch audits with surface touch thermometer to include every room in 100, 200 and 300 halls for the remainder of the season. The facility will follow the safe water temperature of 100 degrees per Appendix PP in the State Operations Manual. - 12/31/24 -Facility will audit safe distance of beds from heater five times a week for 3 months and then quarterly, done by maintenance or assigned person - 12/31/24 -All staff training for identifying and reporting hazards, bed positioning and thermostats. All staff assigned safety hazard in-service training videos to be completed immediately. - 12/31/24 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Purchasing designee actively looking for a safe cover or similar mechanism, if one available - 12/31/24 The scope lowered from a K to a G at the time of the survey after removing the immediacy. The facility identified a census of 60 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severely impaired cognition. The MDS identified Resident #1 required substantial/maximal assistance with rolling left and right in bed and listed them as dependent on staff with transfers. Resident #1's MDS included diagnoses of non-Alzheimer's dementia, malnutrition (inadequate intake of nutrients), depression, arthritis, hyperlipidemia (high cholesterol) and a urinary tract infection (UTI) in the past 30 days. The MDS documented Resident #1 had a risk for developing pressure ulcers/injuries and had one or more unhealed pressure ulcer/injuries. The MDS documented Resident #1 had one unstageable pressure ulcer present on admission or reentry. The MDS documented the following skin and ulcer/injury and treatments: pressure reducing device for chair/bed, nutrition/hydration to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressing and application of ointments/medications. The Care Plan revised on 12/26/24 revealed Resident #1 had a potential impairment to skin integrity related to fragile skin, history of pressure wounds and current wounds/blisters to bilateral lower extremities. The Care Plan documented contributing factors included burns, risk for malnutrition, history of deep vein thrombosis (DVT) and transient ischemic attack (TIA) causing risk with circulation to extremities, and hyperlipidemia causing increased risk with wound healing. The Interventions directed the following: a. Wound management to include skin prep (skin protectant) to the blisters, mupirocin (topical ointment) to open areas, house supplement for wound healing, air mattress, winged mattress for positioning and a wheelchair cushion. b. Resident #1 needed help to complete Activities of Daily Living due to dementia. c. Use a mechanical lift for all transfers. Resident #1 couldn't ambulate. A Fall Scene Investigation Report (FSI) dated 12/8/24 at 12:44 AM revealed the staff observed Resident #1 lying sideways on the bed with his legs out of the bed. The fall huddle findings described Resident #1 as restless due to vascular dementia and recent decrease in the medication Seroquel (antipsychotic). The findings concluded Resident #1 attempted to climb out of bed and slid his legs outside of the low bed. The FSI documented an intervention to prevent falls as to increase the Seroquel and rearrange the room. The Director of Nursing (DON) signed the form on 12/9/24 at 8:15 AM. An Incident/Accident Report dated 12/8/24 at 12:44 AM reflected the staff found Resident #1 with his legs hanging out of the bed touching the heat register, resulting in burns to his bilateral lower extremities. The report documented interventions added to the Care Plan included the following: -Rearrange room with bed across room along east wall (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Elevate legs and treatment as ordered -Maintenance to check heat registers in room and also audit other registers throughout the building -Boundary board checks The Skin/Wound Note dated 12/8/24 at 12:44 AM labeled as a late entry documented a Certified Nursing Assistant (CNA) found Resident #1 lying on his stomach with his legs off the bed. Resident #1's left leg touched the heater and caused two blisters (Blister A and Blister B). Blister A measured 6 centimeters (cm) x 5 cm and popped with movement. Blister B listed as intact and measured 1 cm x 3 cm. The note lacked documentation of treatment to the burn areas at the time of discovery and lacked documentation of immediate interventions. The Skin/Wound Note dated 12/8/24 at 12:00 PM documented Resident #1 had multiple fluid filled blisters of various sizes. The left knee had two blisters. Blister A measured 4.2 cm x 3 cm and Blister B measured 6 cm x 8 cm. The note documented the open blisters had a scant amount of bloody drainage. The note revealed Resident #1's right shin had a red area that measured 7.3 cm x 3.8 cm with a fluid filled blister in the center that measured 1.1 cm x 1.2 cm. The note documented they cleaned the areas, applied skin prep to the intact blisters, mupirocin and a nonstick dressing to the open blisters. The note documented the intervention as the staff moved Resident #1's bed away from the heater and rearranged the room. The facility notified Resident #1's wife and Physician of the incident. The Non-Pressure Skin Condition Record dated 12/8/24 documented 7 burn related areas (A through G) to the left knee/shin. The record described the areas as partial thickness (affected the second layer of skin) with scant amount of serous (clear or yellow, thin, watery fluid) drainage. A - Fluid filled blister - 1.2 cm x 1.3 cm B - Open area - 4.2 cm x 3 cm C - Open area - 6 cm x 8 cm D - Blister - 1 cm x 0.8 cm E - Blister - 1.2 cm x 1.1 cm F - Blister - 5.3 cm x 3.4 cm G - Dark red area - 5 cm x 2cm The Non-Pressure Skin Condition Record dated 12/9/24 (24-hour reassessment) and facility pictures/images dated 12/9/24 of the left knee/shin documented four burn related areas and the following measurements: #1 - fluid filled - 2 x 2.5 #2 - granulation - 12 x 6 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	#3 - fluid filled - 5.8 x 4 #4 - red, intact - 3 x 2 A Physician Progress note dated 12/10/24 documented a physical exam identified Resident #1 had blisters to the skin of the left knee and leg. The Physician directed to apply skin prep to the intact areas and mupirocin to areas that are open, continue the treatment until resolved. The Non-Pressure Skin Condition Record dated 12/16/24 documented 4 burn related areas to the left knee/shin and measurements: #1 - fluid filled - 2 x 2.5 #2 - scab forming, red edges - 12 x 6 #3 - fluid filled - 5.6 x 4 #4 - intact, red - 2.8 x2 The Non-Pressure Skin Condition Record dated 12/20/24 documented 4 burn related areas to the left knee/shin and measurements: #1 - scab covering - 1.5 x 2 #2 - scab covering 90% - 11.8 x 6 #3 - flat blister, partially scabbed - 5.6 x 3 #4 - 2 x 2 The Non-Pressure Skin Condition Record dated 12/23/24 documented 4 burn related areas to the left knee/shin and measurements: #1 - superficial scab - 1.3 x 1.9 #2 - 70% covered with scab - 10 x 3.5 #3 - scab - 5.2 x 2.5 #4 - dark pink - 1.4 x 1.2 The Non-Pressure Skin Condition Record dated 12/23/24 documented 4 burn related areas to the left knee/shin and measurements: #1 - partial thick/superficial scab - 1 x 1.5 #2 - 70% covered with scab, scab lifting - 10 x 3 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	#3 - scab - 5 x 2.3 #4 - new skin, dark pink - 1.4 x 1.2 The Non-Pressure Skin Condition Record dated 12/8/24 documented a burn with a blister to the right shin. The red area measured 7.3 cm x 3.8 cm and the blister measured 1.1 x 1.2. The record documented they applied skin prep. A facility form titled Root Cause Analysis (RCA) and Plan of Correction (POC) for Resident #1 dated 12/8/24 documented the facility had audits in place to check heat register surface temperatures. The POC documented Resident #1's surface temperature for the electric baseboard heater was 124 degrees F which the facility considered was a safe temperature. A facility form/room map titled Heat Register Safe Touch dated 12/9/24 documented the electric baseboard heaters in all of the rooms in the 100, 200, and 300 hallways had surface temperatures ranging from 124 degrees Fahrenheit to 130 degrees Fahrenheit. The Non-Pressure Skin Condition Record dated 12/9/24 (24-hour reassessment) and facility pictures/images documented an intact fluid filled blister to the right shin that measured 3.6 cm (length) x 2.5 cm (width). The Non-Pressure Skin Condition Record dated 12/16/24 described the blistered area to the right shin as open at that time and measured 3.1 cm (length) x 2.6 cm (width). No signs of infection. Non-Pressure Skin Condition Record dated 12/23/24 documented the right shin area as scabbed and measured 3.4 cm (length) x 2.2 cm (width). The Communication with Family/NOK/POA Note dated 12/23/24 at 10:45 PM documented Resident #1's wife saw her husband and told the CNA she was going to call 911 to take her husband to the hospital. The note documented Resident #1's wife talked to a nurse about his burns and showed the nurse pictures she took of his knee. The wife voiced concerns about why they didn't send Resident #1 to the burn hospital right away. The wife reported Resident #1 was going to die and lose his leg. The note documented the nurse gave reassurance to the wife of the doctor's involvement and how they didn't feel he needed to go to the hospital at the time. The note documented that it takes time for the burns to heal. The wife reported the DON had voiced the Physician would be at the facility the following day. The wife reported she would be back in the morning when the Physician came. A Physician Progress note dated 12/24/24 documented Resident #1's chief complaint as his wound wasn't healing. The progress note documented Resident #1 had pain in the left knee, preferred to sit with his leg flexed at 90 degrees at the knee, had pain with extension of the knee, and had superficial wounds around the patella and left anterior knee that were not healing. The Physician ordered x-rays of the left knee/hip, a wound culture of the left knee, lab work that included a CBC (completed blood count) and CRP (c-reactive protein), and a wound clinic referral. The Communication - with Doctor dated 12/24/24 at 2:40 PM indicated the staff reviewed Resident #1's labs with the Physician, who gave new orders to continue Keflex (oral antibiotic) TID for the knee wound. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Crestview Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 South Des Moines Street Webster City, IA 50595	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Transfer to ER Note dated 12/26/24 at 4:36 PM documented Resident #1 went to the emergency room per family request via private vehicle. The Hospital emergency room (ER) Physician Note dated 12/26/24 documented Resident #1 reason for the ER visit as a wound check and nursing home placement. The note documented Resident #1 suffered fairly severe burns on his legs 19 days before and recently started antibiotics. The note documented his legs appeared to heal okay. The wound had a large amount of eschar (dead, nonviable tissue) present. The note documented the final diagnosis as a full thickness burn (3rd degree burn that extends through all layers of skin, completely destroying the skin) of the left lower extremity with the plan to admit to the hospital. The Hospital Wound Assessment and picture/image dated 12/27/24 documented Resident #1 had a thermal burn to the anterior left knee that measured 17 cm (length) x 5 cm (width) x 0.1 cm (depth) with 100% eschar to the wound bed. The Hospital Wound Assessment and picture/image dated 12/27/24 documented Resident #1 had a thermal burn to the right lower leg that measured 3 cm (length) x 1.7 cm (width) and 0.1 cm depth with 100% eschar to the wound bed. The Hospital record titled General Surgery Consult dated 12/27/24 documented they saw Resident #1 for an assessment of his lower legs burn wounds. The consult documented Resident #1 had a very large eschar to the left knee that overlies the patella. Resident #1 also had a dark eschar distal (farther away) to this as well as on the right shin. The progress note documented they managed to debride (remove dead tissue) majority of the dry eschar at the bed side, with very adherent dry eschar remaining over the knee. The note directed to start Santyl (topical enzymatic debridement) as a treatment. The Hospital record titled Wound Debridement Documentation dated 12/27/24 documented they performed excisional debridement (removal of nonviable tissue using a sharp instrument) to his left knee. The debridement involved subcutaneous tissue (deepest layer of the skin) and removal of necrotic, devitalized (tissue not savable due to a lack of blood supply), non-viable (non-savable) tissue. They debrided the wound to viable, fresh, and bleeding tissue. They listed the estimated wound area as approximately less than 20 square cm. Review of Appendix PP in the State Operation Manual (SOM) issued 8/8/24 revealed a safe water temperature of 100 degrees F. The SOM documented the degree of injury depends on factors including temperature, the amount of skin exposed, and the duration of exposure. Table 1 in Appendix PP in the SOM illustrated damage to skin in relation to the temperature of the water and the length of time of exposure for a 3rd degree burn to occur: 155-degree F - 1 second 148-degree F - 2 seconds 140-degree F - 5 seconds 133-degree F - 15 seconds (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	127-degrees F - 1 minute 124-degrees F - 3 minutes 120-degrees F - 5 minutes 100-degrees F - Safe temperature for bathing An article from Geographic Pedia titled, How Hot Can A Human Touch Without Getting Burned? dated 6/22/24 documented the industry standard for safe contact is 140 degrees F, but temperatures above 100 degrees F can still cause damage to the skin with prolonged contact. Researchers found the pain threshold for heat is around 112.3 degrees F and the highest threshold was found in the foot at 112.1 degrees F. The article further documented 140-degrees F could cause third degrees burn on human skin in just one second. On 12/30/24 at 9:18 AM, Resident #1's wife requested the surveyor check all the rooms in the memory care unit to ensure the facility didn't have beds against the heat registers. She stated they had her husband's bed positioned in front of the window and only 6-8 inches from the heat register. She stated he rolled out of bed onto the heat register. She stated she didn't know for sure how long he laid there. She reported he received burns to both of his legs. She reported the heat register as hot to touch and she could not keep her fingers on it. She stated the facility notified her around 12 noon the following day of his injuries. She stated the staff told her they were treating the burns and that the areas were healing. She stated she felt the facility should have sent him to the wound center for treatment. She stated the left knee cap had a really bad burn on it. She added her husband couldn't straighten his left leg as it is too painful. She reported he had a smaller burn on his right shin. She reported she took pictures of the burns at the facility on 12/23/24. She stated she tried to see the wound several times and was not able to. She stated the staff would tell her that they just wrapped his legs. She stated on 12/23/24 she demanded to see the wounds. She stated she told the staff if they didn't unwrap his legs she would remove the dressing herself. She reported she transported her husband to the emergency roiagnom on [DATE]. She stated the hospital admitted her husband and the hospital debrided some of the burn wounds. She stated the hospital applied an ointment to the wounds to soften up the big scab on the left knee. She reported her husband couldn't move without a lot of pain and that he kept his left knee bent. On 12/30/24 at 11:38 AM, an observation of the electric baseboard heater in Resident #1's room (room [ROOM NUMBER]) revealed it as hot to touch on the side of the room Resident #1 resided. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/30/24 at 11:28 AM, Staff A, Registered Nurse (RN), reported Staff B, Certified Nursing Assistant (CNA), came to her and asked for help with repositioning Resident #1. She stated she thought it happened around midnight but couldn't say for sure regarding the time. She stated she thought Staff B got her right away and did not do anything in between. She stated she got in the room and observed Resident #1 laying with his lower legs off the bed with his torso and upper legs still in the bed. She described one leg on top of the other while still wearing his heel lift boots. She stated he had his right shoulder underneath him and he sort of on his stomach. She stated as soon as she got in the room, she moved his legs back into bed. She stated when she grabbed his legs, she felt moisture on his left knee and thought a blister might have popped. She stated his legs were a little warm. She stated on his right shin he had some redness like he laid on something. She stated he didn't have blisters and it didn't puff up at that point. She stated he later did develop blisters on his right leg. She stated they placed a body pillow on the bed on the side of the heater. She stated she left the areas open to air and then later that morning applied a dry dressing to the left knee. She stated the left leg was further down then the right leg and felt the left leg would have touched the heater more than the right. Staff A reported Resident #1 wiggled around a lot. She stated Resident #1 would flop his legs around and grab the hand rail to wiggle his hips. She described Resident #1 as confused and fiddled with things. Staff A reported the heat registers could get pretty warm where it could cause a burn. She stated the facility didn't have the beds right against the heater. She stated they have boards placed on the floor to create a little bit of space. She stated the boards prevent the bed from being smack against the wall/heater, prevent the bed from rubbing on the wall and to keep the blankets from being against the heater. She stated she didn't call the physician or family at the time of the incident. She stated she told the morning nurse to do the notification at a more appropriate time. She stated she text management about Resident #1 needing to be seen by the physician. She stated she continued to check on Resident #1 throughout the shift. She reported she filled out a paper for management about the incident. A hand-written staff statement dated 12/8/24 at 12:44 AM by Staff A documented a CNA came to the door and asked the nurse to help her reposition and change Resident #1. Staff A immediately came into the unit and walked down to Resident #1's room. Staff A observed Resident #1 laying across the bed almost sideways with his right arm under him leaning towards his stomach. He had his left arm up between his pillow and the side rail with his torso and stomach on the bed. He had his body pillow tucked under the fitted sheet on the side of the bed towards the door with the air mattress pad in place within the fitted sheet. Resident #1 appeared to have started on his right side with his head of the bed up and legs raised some. His legs hanged off the bed, knees flexed, between the bed, and the wall. His had his left leg underneath the right one with his heel boots in place. He had his left knee leaning on the heater and his right leg mostly lined up with the other leg but not completely. Staff A immediately ran over and lifted Resident #1's legs back into the bed while Staff B tried to pull him over more from the other side of the bed. When Staff A grabbed Resident #1's legs she felt some wetness, his blister. After Staff A and Staff B got Resident #1 positioned safely on the bed, Staff B stayed with him while Staff A grabbed measuring tools. Staff A and Staff B gently proceeded to change Resident #1's wet brief and reposition him with the body pillow on the other side of the window. On 12/30/24 at 1:15 PM, Staff A reported she left the burn open to air as she wanted the area to cool off. Staff A stated she didn't want to put anything cold immediately on it. She stated she kept going back to check on Resident #1. She described Resident #1 as restless and wiggly and would have picked off or removed a dressing. She stated she didn't want him rubbing or scratching the areas. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/30/24 at 2:15 PM, the Nurse Manager, Licensed Practical Nurse (LPN), reported the facility had boundary boards in the residents' room for years. She stated the boundary boards are in place to keep the beds away from the heaters. She reported she went down to Resident #1's room after the incident, measured the bed to the heat register, and it measured 3 feet away from the heat register. She stated they used a surface temperature gun to check the heat register safe touch temperatures documented in the plan of correction. She stated the facility used Occupational Safety and Health Administration (OSHA) guidelines for the safe temperatures of 140 degrees. On 12/30/24 at 2:28 PM, the Director of Maintenance stated that the heating system in the 100, 200, and 300 hallways were the electric baseboards heaters. He stated each resident room had their own thermostat that controlled the electric heaters. He stated the 400 and 500 hallways are heated by a boiler system, where hot water pumps water to a tube through the basement and produces radiant heat. He stated there are no safe temperatures with the electric baseboard heaters, he stated they could get up to 160 to 180 degrees F. He stated it's a timing thing. He stated the boundary boards on the floor are to keep everything away from the heaters, walls, and electrical outlets, he stated the boards are not the same measurement in each room because it depends on the beds, some rise up and down differently, and some have different legs on the beds. He stated staff are to keep the beds 3 feet away but sometimes the beds get moved and the staff or housekeeping have to move them back. On 12/30/24 at 3:10 PM, the Nurse Manager reported it was her idea to do the surface temperature on the heat registers. She stated she tried to come up with something else for the plan of correction. She reported she thought knowing how hot the surface temperatures of the heat registers were and monitoring periodically would help prevent further concerns. She stated the best intervention was to move the bed from the register. She stated the boundary boards are in place to keep the bed away from the heaters. She stated some rooms staff will put the bedside table in between the wall and bed. She stated if you move the bed too far out there is not enough space for the residents to live. On 12/30/24 at 4:20 PM, The Nurse Manager used the facility equipment with the surveyor present to obtain a surface temperature of the electric baseboard heater in room [ROOM NUMBER]. The surface temperature registered 124 degrees F. She took an additional surface temperature in room [ROOM NUMBER] with a temperature registered at 116 degrees F. On 12/30/24 at 4:23 PM, Staff B reported she as she did the first rounds, she made it to Resident #1's room, she observed him lying on his stomach, with his upper torso in bed, hands near the side rail, and legs off the bed by the heat register. She reported she thought it was around midnight. She stated she hadn't worked at the facility that long and didn't know about the heat register or it being on. She stated she pulled the call light in the bathroom for help. She stated the nurse came in after she pulled the light. She stated the nurse told her about the heat register. She stated they got Resident #1 off the heat register right away. She reported Resident #1 had slept during the incident. She stated she checked on Resident #1 after she got report from the second shift CNAs around 10:40 PM. She stated at that time he laid on his side facing the door and held onto the side rail. She reported after the incident she pushed the bed out, put the body pillow in place and tucked the pillow under the fitted sheet on the side of the bed with the heater. She stated after the incident she checked on him more frequently. She stated when she got him back into bed he had red marks and forming blisters on his bilateral lower legs. She stated the nurse wrapped his leg but did not remember which leg. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A hand-written staff statement dated 12/8/24 by Staff B documented at midnight they went into Resident #1's room to change him for rounds. Staff B documented she did a visual check around 10:45 PM. When Staff B went into Resident #1's room, she found Resident #1 sleeping on his stomach with his legs off the bed. Staff B pulled Resident #1's call light for help. Staff B documented she didn't know he had a heat register there and on until Staff A said something. Staff B documented Staff A helped her get Resident #1 back into bed. On 12/30/24 at 4:43 PM, Staff C, RN, reported Staff A passed on in report the aide found Resident #1 with his legs out of the bed when she went in to change him. Staff C stated when Staff A went into the room to help she observed Resident #1 with his legs on the heater. Staff C stated Staff A told her Resident #1 had blisters on his legs. She stated she checked on him first and completed the needed paperwork. She stated she notified the Physician, family, nurse manager, and DON regarding the incident. She stated he had blisters and open areas on both lower legs. She stated the left knee developed a bigger wound as the areas came together. She stated the Nurse Manager obtained treatment orders to apply mupirocin to the open areas and skin prep to the unopen blisters. She stated she rearranged the room and moved the bed completely away from the heater. She stated Resident #1 had a wing mattress and an air overlay. She stated she got rid of the air overlay so the wing mattress would work better. She stated when she called the wife to report the incident, the wife wanted to know why someone didn't call her right away. She stated the wife relayed she wanted to be called anytime of the day. She stated the wife came in later that day and liked how the room rearrangement. On 12/31/24 at 9:15 AM observed a boundary board in front of the electric baseboard heater in room [ROOM NUMBER]. The board measured 7.5 inches (width) from the edge of the heater to the edge of the board. The electric baseboard heater didn't have a protective cover. The baseboard heater felt hot to touch, a person couldn't leave their hand/fingers on the electric baseboard heater for more than a couple of seconds. On 1/6/25 at 9:36 AM, the Director of Nursing (DON) reported she put the air mattress back in place the following day after the incident, once they rearranged Resident #1's bed and moved it away from the heater. A facility policy titled Accident and Supervision dated 2024 described the facility policy as to ensure the resident environment would remain free of accidents hazards as much as possible. The policy documented each resident would receive adequate supervision and assistance to prevent accidents which included: a. Identifying hazards and risks b. Evaluating and analyzing hazards and risks c. Implementing interventions to reduce hazards and risks d. Monitoring for effectiveness and modifying interventions when necessary.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on record review, staff interview and policy review, the facility failed to have a Physician or a Non-Physician Practitioner (NPP) provide a face to face visit which includes a comprehensive assessment once every 60 days for 1 of 6 residents (Residents #3) reviewed for Physician Services. The facility reported a census of 60 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMs) score of 3, indicating severely impaired cognition. The MDS identified Resident #3 as independent with bed mobility, transfers, and toileting. The MDS included diagnoses of hypertension (high blood pressure), hyperlipidemia (high cholesterol), other fracture, non-Alzheimer's dementia, cerebrovascular accident (CVA) (stroke), and chronic lung disease. The Clinical record revealed the Physician saw Resident #3 on 8/6/24, 9/4/24, and 10/15/24. The Clinical lacked documentation a Physician saw Resident #3 after 10/15/24. On 1/6/25 at 12:14 PM, the DON (Director of Nursing) verified they missed Resident #3 so she didn't see a Physician on rounds in December 2024 by two different Physicians who had rounded at the facility. A facility policy titled Physician Visit and Physician Delegation dated 2024 documented the facility policy as to ensure the Physician took an active role in supervising the care of the resident. The policy instructed the resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by a Physician or Physician delegate as appropriate by State law.