

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Crestview Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513</p> <p>Based on staff interviews, observations and insulin pen manufacturer directive the facility failed to follow professional standards for 3 of 7 residents observed during medication administration (Residents #27, and #17). The facility reported a census of 59.</p> <p>Findings include:</p> <p>Resident #27's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS reflected Resident #27 received insulin injections during the last seven days lookback period. The MDS included diagnoses of renal (kidney) failure, diabetes, anemia (low blood iron) and orthostatic hypotension (sudden change in blood pressure with position changes).</p> <p>The Care Plan Focus dated 12/29/23 indicated Resident #27 had a risk for ketoacidosis (complication of high blood sugars) related to insulin therapy. The Goal listed to avoid adverse effects from insulin use. The Interventions directed staff to observe and report signs and symptoms of lab results, profound dehydration (not enough fluid in the body), elevated blood glucose, ketones (form of protein showing elevated blood sugars in urine), excessive thirst, frequent urination, nausea, vomiting, abdominal pain, weakness, fatigue, shortness of breath, fruity scented breath, confusion, rapid respirations, and elevated temperature.</p> <p>The October 2024 Electronic Record Order Administration directed use to use (manufacture name left out) Insulin Pen Needle. Inject one pen needle subcutaneously three times a day related to diabetes. Inject 5 unit subcutaneously (under the skin into the fatty tissue) with meals related to diabetes.</p> <p>On 10/22/24 at 5:07 PM observed Staff B, Licensed Practical Nurse (LPN), enter Resident #27's room. Staff B reported they had five (5) units of insulin to give Resident #27. Staff B gave Resident #27 the insulin injection in his abdomen per his choice, Staff B immediately removed the insulin pen after the injection.</p> <p>On 10/22/24 at 5:15 PM, watched Staff B carry a small plastic tray down the hall into the dining room. The tray contained 2 small clear plastic unlabeled medication cups, containing pills and 2 cups of clear liquid. Staff B offered 1 medication cup of pills to Resident #17 with the cup of fluid. Resident #17 took the medication and handed the empty medication cup back to Staff B. Staff B proceeded to another resident and gave them the other medication cup with the pills and the other cup of liquid. Staff B failed to complete hand hygiene before or after giving the medications.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/22/24 at 5:21 PM, Staff B reported they knew they should have done the task differently. Staff B explained they had professional training on medication administration and should have held the insulin syringe in place several seconds before withdrawing. Staff B, added her training included correct insulin pen administration and she realized she didn't follow the training received. Staff B confirmed she did set up medications for multiple residents, and should have administered each medication separately verses setting up medications for two residents. In addition, Staff B acknowledged she should have performed hand hygiene in between each resident medication administration.</p> <p>In an interview on 10/23/24 at 5:10 PM the Director of Nursing (DON), voiced Staff B knew better. The DON expected the staff to not to deliver several unlabeled medications to residents at the same time, to perform hand hygiene, and to follow the correct processes when administering insulin. The DON acknowledged Staff B shouldn't have withdrew the pen immediately after administration.</p> <p>The BD Autosheild Due Safety Pen Needle with Dual Automatic Protective Shields form dated 2023 insulin pen, instructed to inject insulin into the skin at a 90 degree angle, maintain constant pressure against the skin, push the dose button, and leave the needle in the skin for up to 10 seconds.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513</p> <p>Based on resident interview, staff interviews, record review, and manufacturer guide booklet the facility failed to ensure a resident's safety for 1 of 3 residents reviewed for accidents (Resident #27). As the staff helped Resident #27 prepare to take a bath, they failed to secure him in the chair with the seat belt. As they lifted the shower chair, Resident #27 fell from the shower chair to the floor. The facility reported a census of 59 residents.</p> <p>Findings include</p> <p>Resident #27's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #27 required partial/moderate assistance with showering/bathing. The MDS included diagnoses of renal (kidney) failure, diabetes, anemia (low blood iron) and orthostatic hypotension (sudden change in blood pressure with position changes).</p> <p>The Care Plan Focus revised 12/29/23, documented Resident #27 had a risk for falling due to weakness. The Care Plan Interventions dated 7/11/24 indicated Resident #27 fell out of the bathtub chair after having a coughing episode. At the time Resident #27 didn't wear his seat belt per his request. The facility educated the staff and Resident #24 regarding the need of using a bathtub strap.</p> <p>The Incident Note dated 7/11/24 at 9:35 AM, Staff C, Registered Nurse (RN), documented staff summoned her to the shower room. Upon arriving Staff C assessed Resident #27 as alert and oriented times four (aware of person, place, time, and situation) per his baseline. As Resident #27 got ready to take a bath in the shower room, the staff member reported while they lifted him up in the bath chair approximately one foot from the ground, Resident #27 began coughing, became pale, tipped out of the bath chair, and onto the floor. Resident #27 didn't have his seat belt on in the bath chair. Staff C initiated neurological (neuro) checks. He had vital signs within normal limits (WNL), his extremities had range of motion (ROM) WNL, he wore no footwear, dry, adequate lighting, and free of clutter. Resident #27 requested to not have a safety shower belt on after getting in the bath chair. Resident #27 had goose egg above his left eye/forehead area, and a scuffed up left knee. Staff C offered him pain medication, which he denied. Resident #27 requested a cool cloth to his forehead. Two staff assisted Resident #27 to a standing position then back into the shower chair. Staff C notified Resident #27's contacts including his provider of his fall. The provider would see Resident #27 on rounds that day. The facility implemented an intervention of staff and resident education on using the bath safety belt while in the bath. Staff C noted no further concerns.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a Provider Note dated 7/11/24 at 12:19 PM, the Nurse Practitioner (NP) documented Resident #27 sustained a fall from the shower chair that morning. He refused to wear the seatbelt provided in the past. He fell on his left side striking his left forehead on the floor. He had a 2 centimeter (cm) raised area to his left forehead with no visual bruising. He didn't take an anticoagulant. Resident #27 has a 1 cm oval intact red area below his left knee. His neuro checks are WNL and he could move all extremities. He denied pain except for a tender left forehead. He declined acetaminophen or any pain medication intervention. The nurse educated Resident #27 and the staff to ensure the shower chair seat belt is in place. Resident #27 educated during the visit and he agreed to wear the shower chair seatbelt going forward. Further detailed assessment of body systems noted, also identified as awake, alert, cooperative, clear speech, in no acute distress, at baseline cognition, and normal speech.</p> <p>In an interview on 10/22/24 at 4:24 PM, Resident #27 reported he fell out of the shower chair. Resident #27 stated that Staff A, Certified Nurse Assistant (CNA), forgot to put on his seat belt. Resident #27 expressed he didn't refuse, they forgot. He added all the other girls put the seatbelt on him when he sits in the bath chair. Resident #27 said he couldn't remember exactly why he fell , but he could have gotten dizzy. Resident #27 explained he received assistance right away.</p> <p>On 10/22/24 at 5:30 PM, Staff A, Certified Nurse Aide (CNA), recalled when she went to give Resident #27 a bath, she asked if he wanted the seat belt. Resident #27 responded, no. Staff A reported as they lifted Resident #27 up in the chair, several feet, he started coughing, went limp, and fell from the chair on to his left side hitting his head on the floor. Staff A stated she wasn't thinking and knew she should have put the seat belt on Resident #27. Staff A explained another staff member retrieved Staff C who came right away. Staff A said she got training afterwards which included all residents need to wear a seatbelt.</p> <p>In a joint interview/observation on 10/23/24 at 1:52 PM, the Director of Nursing (DON), and Administrator joined a tour of the whirlpool room. The observation of the tub revealed a height of approximately 3 feet tall. The Administrator and DON demonstrated how the chair went up mechanically, about 3.5 to 4 feet, to go over the tub to get the chair and resident into the tub. They also showed the straps in the chair. The Administrator voiced Resident #27 didn't want the belt on, as he often refused, as he has rights. She described Resident #27 as his own person, alert, oriented, and cognitively aware. The DON voiced she expected all residents to wear a belt and she would never recommend doing a shower without a seat belt. The Administrator agreed resident safety must be considered.</p> <p>In an interview on 10/23/24 at 6:02 PM, Staff C relayed the unit staff summoned her, while Staff A stayed with Resident #27, after he fell from the shower chair. Staff C stated she arrived right away, finding Resident #27 awake and alert. Staff C stated Staff A reported she pushed the pedal raising the shower chair, Resident #27 coughed. She stopped lifting the bath chair. Staff C described the bath chair lifted about a foot up and definitely not all the way up. Staff C knew that because the shower chair remained in the same level as when he fall. Staff C reported Resident #27 said he didn't want the belt. Staff C described Resident #27 after the fall had a goose egg, they started neurological assessments and did vital signs. Staff C relayed the assessment showed Resident #27 at baseline status, without complications.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 3:26 PM, Staff E, CNA, reported she gave Resident #27 a spa bath before and he never refused to wear the seatbelt. She wouldn't give a spa bath if a resident refused to wear the seatbelt. Staff E said no resident ever refused to put on the seat belt and she had training to always put on the seatbelt.</p> <p>On 10/23/24 at 3:30 PM, Staff F, Licensed Practical Nurse (LPN), and Staff G, RN, reported they haven't given spa baths to the residents, however, have been in the shower room during baths. Both nurses said they always need to use the seatbelt on the spa lift. When asked what they would do if a resident refused to wear the bath seatbelt, they both responded it wouldn't be ok. Staff G stated a CNA couldn't make that decision and would expect them to inform a nurse.</p> <p>An undated manufacture booklet for the Bath System, documented WARNING, failure to ensure the transfer seat is securely fastened to the transfer before the resident is transferred could result in injury to the operator or patient, recommended belting technique diagram pictures included. Also directed to transfer the resident into the shower chair using the proper nursing transfer techniques. Secure the seat belt around the resident, keeping the belt low fastened around the resident.</p>