

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Crest View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 420 Gordon Avenue Chadron, NE 69337	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>49766</p> <p>Licensure Reference Number 175 NAC 12-006.09(H)</p> <p>Based on observations, interview, and record review, the facility failed to provide services to maintain the personal hygiene for 1 (Resident 3) of 4 sampled residents. The facility identified a census of 30.</p> <p>Findings are:</p> <p>A record review of an Admission Record indicated the facility admitted Resident 3 on 6/8/2023 with diagnoses of Alzheimer's disease (a brain disorder that causes memory loss and other cognitive decline) and osteoarthritis (a chronic joint disease that causes pain and stiffness).</p> <p>A record review of Resident 3's quarterly Minimum Data Set (MDS- a standardized assessment tool used to evaluate the health of residents in nursing homes) with an Assessment Reference Date of 2/6/2025 indicated Resident 3 had a Brief Interview for Mental Status (BIMS- a structured evaluation aimed at evaluating aspects of cognition in elderly patients) score of 3/15, which indicated Resident 3 had severe cognitive impairment. The MDS also revealed Resident 3 was fully dependent on staff for personal hygiene and dressing.</p> <p>A record review of Resident 3's Care Plan revealed a focus area, initiated on 6/15/2023, revealed Resident 3 had an Activities of Daily Living (ADL) self-care performance deficit related to Alzheimer's disease progression with interventions for staff to provide extensive assistance for personal hygiene.</p> <p>A record review of the facility's Grievance Tracking Log revealed a grievance was received on 6/18/2024 from Resident 3's family member regarding Resident 3's face and clothing having been unkempt. It also revealed the grievance was resolved on 6/18/2024 by having staff provide care to Resident 3 and later staff education was provided.</p> <p>An observation on 2/24/2025 at 11:05 AM revealed Resident 3 had been sitting in the common's area. Resident 3 had been wearing a dark navy tee-shirt and grey sweatpants. Resident 3's tee-shirt had been scattered throughout with white flakes of an unidentified substance, several areas of dried fluids spots, and crusted area of food debris on the left shoulder sleeve. Resident 3's sweatpants also had several spots of dried fluids and food debris.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 2/24/2025 at 1:00 PM revealed Resident 3 to be sitting in the dining room. Resident 3 continued to have on the same tee-shirt and sweatpants with dried fluid stains and food debris.</p> <p>An observation on 2/24/2025 at 2:55 PM revealed Resident 3 had returned to sitting in the commons area. Resident 3 continued to have on the same tee-shirt and sweatpants with dried fluid stains and food debris. Resident 3 also had yellow food debris on the right side of their mouth.</p> <p>An observation of Resident 3 on 2/24/2025 at 1:00 PM revealed Resident 3 to be sitting in the dining room eating. Staff were noted to be providing cueing to Resident 3. Resident 3 clothing continues to have food debris and stains of dried fluids on their shirt and pants.</p> <p>An interview on 2/24/2024 at 2:10 PM with Resident 3's family member confirmed the family member had filed a grievance in June 2024 regarding Resident 3 being unclean. Resident 3's family member said the facility did provide care to restore Resident 3's hygiene and improvements were made but did not last long. Resident 3's family member revealed ongoing concerns of lack of hygiene care being provided. Resident 3's family member revealed Resident 3's face and clothing are always dirty when the family member visits at least twice a week.</p> <p>An interview on 2/24/2025 at 3:00 PM with the Director of Nursing (DON) confirmed Resident 3's clothing and face were dirty and needed to be cared for. The DON revealed expectations that staff should have provided cares to wash Resident 3 after the meal and should have changed Resident 3's clothing when assisting with toileting every two hours if the clothing was found to be dirty.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>49766</p> <p>Licensure Reference 175 NAC 12-006.09(H)(iii)(2)</p> <p>Based on record reviews and interviews, the facility failed to provide monitoring of pressure ulcers (a localized injury to the skin and underlying tissue caused by prolonged pressure on a specific area of the body, often occurring over bony prominences like the heels, hips, or tailbone, leading to tissue damage and potential open sores if left untreated; this typically happens in people who are immobile or confined to a bed or wheelchair for extended periods) and treatments for the pressure ulcers as ordered for 1 (Resident 1) of 2 sampled residents. The facility identified a census of 30.</p> <p>Findings are:</p> <p>A record review of a facility policy Skin Program Policy with a last revised date of March 2019 revealed in the policy statement that care, and services would be provided to promote the healing of pressure ulcers that are present. The policy revealed procedures to complete a comprehensive wound assessment including site, stage, size, appearance of the wound bed, undermining, depth, drainage, and status of peri-wound tissue and the use of a pressure ulcer monitor tool at least weekly for monitoring. The policy also included direction that the comprehensive wound assessments were to be placed in the resident's medical record. In addition, the policy revealed treatment including cleansing, debriding, and dressing changes were to be provided as ordered.</p> <p>A record review of an article from The National Institute of Health, titled Wound Dressings from 1/23/2024 indicated that nurses should adhere to the dressing change schedule to re-evaluate the wounds to ensure that the wound bed is vascularized (has blood flow), has viable tissue, and is infection-free.</p> <p>A record review of an Admission Record indicated the facility admitted Resident 1 on 1/11/2020 with diagnoses of diabetes and heart disease.</p> <p>A record review of Resident 1's annual Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) with an Assessment Reference Date (ARD) of 12/18/2024 revealed Resident 1 had two Stage 2 (wounds that are open and have partial thickness loss of the skin) pressure ulcers that were not present upon admission with treatments including pressure reducing devices for Resident 1's chair and bed, repositioning program, nutritional intervention, pressure ulcer care, and application of ointment or medication.</p> <p>A record review of Resident 1's Care Plan revealed a focus area, last revised on 6/26/2024, for Resident 1's pressure ulcer development due to immobility. Interventions included to provide treatments as ordered and monitor for effectiveness. On 1/18/2024, an additional focus area was revised to reflect Resident 1's potential for impaired skin integrity with an intervention to assess the resident for skin breakdown each bath day.</p> <p>A record review of Resident 1's Order Summary with active orders date as of 2/25/2025 revealed the following orders:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Change mepilex (an absorbent foam dressing) on bath days and as needed every Wednesday on dayshift with a start date of 5/1/2024.</p> <p>- Cleanse upper buttock wounds with wound cleanser, then apply Optifoam every 72 hours or as needed if soiled with an active start date of 12/7/2024.</p> <p>- Nurse to complete a weekly skin assessment and document a skin/wound progress note every Wednesday on day shift with a start date of 1/18/2023.</p> <p>A record review of Resident 1's Treatment Administration Record (TAR) for December 2024 revealed an order to cleanse upper buttock wounds with wound cleanser then apply an Optifoam dressing was documented as not completed on 12/16/2024 with a reasoning of Other/See Progress Note.</p> <p>A record review of Resident 1's Progress Note from 12/16/2024 revealed the order to cleanse upper buttock wounds with wound cleanser, then apply an Optifoam every 72 hours was documented as not completed with a reason of dressing I clean/dry intact, therefore dressing not changed now.</p> <p>A record review of Resident 1's TAR for February 2025 revealed Resident 1's order for the nurse to complete a weekly skin assessment was documented as not completed on 2/5/2025 with a reasoning of Other/See Progress Note.</p> <p>A record review of Resident 1's Progress Notes from 2/5/2025 at 6:41 PM revealed the order for the nurse to complete a weekly skin assessment was not completed with reason of resident had no bath today, therefore no skin assessment completed.</p> <p>An additional record review of Resident 1's TAR for February 2025 revealed Resident 1's order to change mepilex on bath days and as needed was documented as not completed on 2/5/2025 with a reasoning of Other/See Progress Note.</p> <p>A record review of Resident 1's Progress Notes from 2/5/2025 at 9:53 AM revealed the order to change the mepilex dressing on bath days and needed was not completed with a reason of dressing clean/dry/intact, therefore not changed now.</p> <p>An additional record review of Resident 1's TAR for February 2025 revealed Resident 1's for the nurse to complete a weekly skin assessment had not been documented as completed on 2/19/2025.</p> <p>A record review of Resident 1's Progress Notes from 2/19/2025 at 5:52 PM revealed the order for a weekly skin assessment was not completed with a reason of resident had no bath today.</p> <p>An additional record review of Resident 1's TAR for February 2025 revealed Resident 1's order to change mepilex on bath days and as needed was documented as not completed on 2/19/2025 with a reasoning of Other/See Progress Note.</p> <p>A record review of Resident 1's Progress Notes from 2/19/2025 at 6:31 PM revealed the order for change mepilex on bath days and as needed was not completed with reason of area open to area, no dressing in place.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 1's Progress Notes from 10/2/2024 to 2/20/2024 revealed the following documented skin assessments:</p> <ul style="list-style-type: none"> - 10/2/2024: Resident 1 Resident continues to have open area to right buttock, measures approximately 0.8cm X 0.7cm. - 10/13/2024: Resident 1 has two small open areas on her right buttocks. Has 2 small 1cm long and 0.5cm long. - 10/19/2024: Resident 1's open area on right buttock measured 1.75 cm (L) X 0.25 cm (W) and had no other open areas. - 10/22/2024: Resident 1 has multiple unmeasurable open areas on bilateral buttocks and sacrum. - 11/2/2024: Resident 1 has 4 small wounds on buttocks and sacrum. Wounds superficial, no drainage noted from sites. - 12/4/2024: Resident 1 has 4 small open skin areas on upper buttocks, toward center, each wound measures less than 0.5 cm. Wounds cleansed with wound cleanser and an Opti foam applied. No drainage/bleeding observed. - 12/7/2024: Resident 1's sacrum has 6-8 small open areas, 0.5 CM circles. Area is close to [their] rectum. - 12/11/2024: Resident 1 continues to have small open areas on sacrum. - 12/13/2024: Resident 1 continues with open skin areas near sacral area, wounds cleansed with wound cleanser and Optifoam dressing applied. No drainage or surrounding redness of open skin areas. - 12/18/2024: Resident 1 has wound on bilateral bilateral buttocks remains red and raised.12/25/2024: Resident 1 continues to have small open areas on sacrum. With redness and small amount of clear light red drainage at the site. - 12/28/2024: Resident 1 continues to have small open areas on sacrum. Wounds cleaned with wound cleanser and covered with mepilex. With small amount of redness at the site. - 1/8/2024: Resident 1 Continues to have have superficial open areas on sacrum. Covered with optifoam. - 1/15/2024: Resident 1 continues to have open areas on sacrum. Wound covered with Optifoam. Denies pain. No surrounding redness. - 1/22/2025: Resident 1 has small open areas in sacrum. Covered with mepilex. - 1/29/2025: Resident had a bath, continues with small open skin areas near sacrum, optifoam applied. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 2/12/2025: Revealed a skin noted continues with healing open skin areas on coccyx area. Opti-foam dressing applied. No bleeding/drainage.</p> <p>- 2/20/2025: Resident 1 has area over [their] right upper buttocks that needed an opti-foam for protection. Has 4-5 scattered small circles that are not healed yet. Applied opti-foam on areas for protection from urine and BM (bowel movement).</p> <p>An interview on 2/24/2024 at 3:00 PM with the Director of Nursing revealed the facility does not have a process in place for monitoring wound progress to see if it is improving or not. Wounds are only measured if the resident receives care by the Wound Clinic and measured there, otherwise, the staff do not measure the wounds. The nurses are to place a progress note of skin assessment with the resident's bath.</p> <p>An interview on 2/25/2025 at 12:00 PM with MDS-B revealed skin assessments should be completed even if a resident does not receive a bath and wound dressing changes should be changed as ordered regardless of if the dressing is clean, dry, and intact. The MDS-B also revealed pressure ulcers should be re-evaluated weekly to monitor progress including measurements. MDS-B confirmed Resident 1's progress note did not reflect the monitoring of Resident 1's pressure ulcer status.</p>