STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285150	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest View Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49766 Licensure Reference 175 NAC 12-006.05(S) Based on observation, interview, and record review; the facility failed to protect resident dignity and right to privacy by ensuring privacy during personal cares for 1 (Resident 13) of 4 sampled residents. The facility identified a census of 31. Findings are: A record review of a facility policy Resident Rights Policy with a last revised date of November 2019, under section 8. Privacy and Confidentiality, indicated the resident has a right to personal privacy during personal cares. A record review of an Admission Record indicated the facility admitted Resident 13 on 6/8/2023 with a diagnosis of Alzheimer's disease. A record review of Resident 13's quarterly Minimum Data Set (MDS, a comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents) with an Assessment Reference Date (ARD) of 8/6/2024 revealed Resident 13 had a Brief Interview for Mental Status score of 3/15, which indicated Resident 13 had severe cognitive impairment. The MDS also indicated Resident 13 required moderate assistance for toileting. An observation on 9/3/2024 at 11:39 AM revealed Resident 13 was in the commons area with two other residents present. Nurse Aide (NA)-C checked Resident 13's brief by pulling down their pants. An interview on 9/3/2024 at 12:21 with NA-C confirmed NA-C had checked Resident 13's brief to see if Resident 13 was incontinent in the commons area by pulling down their pants. NA-C confirmed NA-C should have taken Resident 13 back to their room and provided privacy to check Resident 13 for incontinence.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49766 Licensure Reference 175 NAC 12-006.04(F)(i)(5) Based on interviews and record reviews, the facility failed to notify the physician of significant weight loss for 2 (Resident 17 and 21) of 2 sampled residents. The facility identified a census of 31. Findings are: A. A record review of a facility policy Nutrition Unplanned Weight Loss Clinical Policy with a last revised date of March 2019 revealed a significant weight loss is 10% in six months. Under section Recording Weights and Follow-Up, the policy revealed nursing will notify the MD of the weight change. A record review of Resident 17's Vitals revealed Resident 17 weighed 164.5 pounds on 2/6/2024 and on 8/6/2024 Resident 17's weight was 143.5 pounds, which was a loss of 21 pounds or 12.77% loss since the weight on 2/6/2024. A record review of Resident 17's medical record did not reveal any evidence that Resident 17's physician was aware of the significant weight loss. An interview on 9/3/2024 at 2:24 PM with the Director of Nursing (DON) confirmed Resident 17's physician had not been notified of Resident 17's significant weight loss. The DON confirmed the physician should have been notified of Resident 17's significant weight loss. 49263 B. A record review of a facility policy Nutrition Unplanned Weight Loss Clinical Policy with a last revised date of March 2019 revealed a 5% weight loss in one month was significant. Under section Recording Weights and Follow-Up, the policy revealed nursing would notify the MD (the resident's medical provider) of the weight change. A record review of Resident 21's Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning, dated 8/6/24 revealed that Resident 21 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a prescribed weight loss program. A record review of Resident 21's weights revealed that on 7/8/2024, the resident weighed 99.5 pounds and on 8/6/2024, the resident weighed 92 pounds which was a 7.54 % loss in one month. A record review of a scanned document in Resident 21's electronic health record (EHR) revealed Resident 21 was seen by their primary provider on 8/6/24 for their 60-day visit. The provider wrote that there were no new orders. There was no evidence in the provider visit documentation that the provider had been made aware of the resident's significant weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of a scanned document in Resident 21's EHR revealed Resident 21 was seen by their primary provider on 8/9/24 due to the resident not feeling well. There was no evidence in the provider visit documentation that the provider had been made aware of the resident's significant weight loss. An interview on 9/4/24 at 9:05 AM with the Director of Nursing (DON) confirmed that Resident 21's primary provider had not been notified of their significant weight loss and there had been no new interventions put into place to mitigate Resident 21's weight loss. An interview on 9/4/24 at 11:05 AM with the DON revealed that the DON had weighed Resident 21 that day and the resident's weight was 97 pounds. The DON stated that Resident 21's weight documented in August 2024 had to have been incorrect. The DON confirm Resident 21's documented weight at the beginning of August 2024 was a significant weight loss from the prior month's weight and had been identified as such but there was no re-weigh done at the time to verify the loss, no physician notification of the loss, and no new interventions had been put into place.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09(B) Based on record review and interview, the facility failed to accurately document falls with major injury for 1 (Resident 27) of 12 sampled residents and to accurately document antiplatelet use for 1 (Resident 6) of 12 sampled residents in their Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning. The facility census was 31. The Findings Are: A. A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities, revealed that major injuries were those that resulted in bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematomas. A record review of Resident 27's MDS, dated [DATE] revealed in Section J that Resident 27 had had two or more falls with major injury since their prior MDS assessment. A telephone interview on 9/4/24 at 12:27 PM with the MDS Coordinator confirmed that Resident 27's MDS dated [DATE] did indicate that the resident had two or more falls with major injury since their prior MDS assessment. An interview on 9/4/24 at 12:20 PM with the Director of Nursing (DON) confirmed Resident 27 did have one fall with major injury on 2/22/24 but there had been no other falls with major injury since Resident 27 was admitted to the facility. 49766 B. A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual indicated to code aspirin under antiplatelet medication and warfarin or heparin under anticoagulant if the resident had taken within 7 days of the assessment. A record review of Resident 6's MDS with a date of 8/6/2024 in Section N indicated Resident 6 had been taking an anticoagulant and was not marked for taking an antiplatelet. A record review of Resident 6's Order Summary with an active order date of 7/30/2024 revealed Resident 6 had been taking aspirin once a day. There was no evidence Resident 6 had been taking warfarin or heparin. A telephone interview on 8/29/2024 at 1:15 PM with the MDS Coordinator confirmed that Resident 6's MDS, dated [DATE], should have reflected Resident 6 had been taking an antiplatelet medication and not an anticoagulant.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49766 Based on record reviews and interview, the facility failed to develop interventions after falls for 1 (Resident 17) of 2 sampled residents. The facility identified a census of 31. Findings are: A record review of a facility policy Fall Prevention and Response Policy with a last revised date of October 2022 revealed post fall documentation included placing a new intervention after each fall. A record review of an Admission Record indicated the facility admitted Resident 17 on 8/17/2022 with diagnoses of epilepsy and vascular dementia. A record review of Resident 17's quarterly Minimum Data Set (MDS, a comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents) with an Assessment Reference Date (ARD) of 7/9/2024 indicated Resident 17 had severe cognitive impairment. The MDS also revealed Resident 17 had two falls without injury, two falls with minor injury, and one fall with major injury. A record review of Resident 17's Progress Notes with a date of 3/2/2024 indicated Resident 17 had an unwitnessed fall and was complaining of right wrist pain. Resident 17 was sent to the Emergency Department where it was determined Resident 17 had a right arm fracture. A record review of Resident 17's Progress Notes with a date of 10/26/2023 indicated Resident 17 had been attempting to stand up and had fallen without injury. A record review of Resident 17's Progress Notes with a date of 9/18/2024 indicated Resident had been found on the floor twice within an hour with injuries of abrasion to left knee and ankle. A record review of Resident 17's Progress Notes with a date of 9/17/2024 indicated Resident 17 had an unwitnessed fall in their bathroom without injuries observed. A record review of Resident 17's Progress Notes with a date of 9/14/2023 indicated Resident 17 had fallen in their room without injury. A record review of Resident 17's Care Plan indicated Resident 17 had a history of falls related to unsteady gait and poor balance. There was no evidence of interventions placed after falls on 9/17/2023 or 10/26/2023. An intervention for Resident 17's fall on 9/14/2023 stated Resident has the right to refuse cares and has the right to fall, resident has been educated of risks vs. benefits of refusing cares and assistance. An intervention for Resident 17's fall on 9/17/2023 stated Resident has right to fall. This is agreed upon by provider and family due to resident refusal to follow any interventions in place. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 9/3/2024 at 4:04 PM with the Director of Nursing (DON) confirmed no interventions were placed for Resident 17's fall on 9/17/2023 or 10/26/2023. The DON also confirmed the interventions for Resident 17's fall on 9/14/2023 and 9/18/2023 were not appropriate interventions to prevent additional falls for Resident 17.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49766 Licensure Reference 175 NAC 12- 006.09(H)(i)(3) Based on observations, interviews, and record reviews; the facility failed to provide assistance with toileting and incontinence care for 2 (Resident 13 and 17) of 2 sampled residents. The facility identified a census of 31. Findings are: A. A record review of a facility policy ADL Assistance Provided Per Care Plan with a revision date of September 2022 revealed incontinent residents shall be checked in accordance with their care plan. A record review of an Admission Record indicated the facility admitted Resident 17 on 8/17/2022 with diagnoses of epilepsy and vascular dementia. A record review of Resident 17's quarterly Minimum Data Set (MDS, a comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents) with an Assessment Reference Date (ARD) of 7/9/2024 indicated Resident 17 had severe cognitive impairment. The MDS also indicated Resident 17 required extensive assistance with toileting. A record review of Resident 17's Care Plan with a last review date of 7/19/2024, under the fall section, revealed an intervention to offer assistance to the bathroom every two hours and offer assistance to the bathroom before meals. A continuous observation on 9/3/2024 from 8:58 AM to 12:14 PM revealed Resident 17 had not been offered assistance to the bathroom. An observation on 9/3/2024 at 12:14 PM revealed Nurse Aide (NA) -E assist Resident 17 from the commons area to the dining room without offer assistance to the bathroom. An interview on 9/3/2024 at 12:15 PM with NA-E confirmed Resident 17 had not been offered assistance with toileting since before breakfast and also confirmed Resident 17 should have been offered toileting at least before their meal. B. A record review of an Admission Record indicated the facility admitted Resident 13 on 6/8/2023 with a diagnosis of Alzheimer's disease. A record review of Resident 13's quarterly MDS with an ARD of 8/6/2024 revealed Resident 13 had a Brief Interview for Mental Status score of 3/15, which indicated Resident 13 had severe cognitive impairment. The MDS also indicated Resident 13 required moderate assistance for toileting. A record review of Resident 13's Care Plan with a last reviewed date of 8/9/2024 revealed no evidence of how frequent to offer Resident 13 with toileting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation on 9/3/2024 from 10:15 AM to 12:21 PM revealed Resident 13 had not been assisted with toileting. An interview on 9/3/2024 at 12:21 PM with NA-C revealed NA-C only toilets residents before breakfast, after lunch, and before dinner. An interview on 9/3/2024 at 1:50 PM with the Director of Nursing confirmed residents should be assisted with toileting every two hours.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49766 Licensure Reference 175 NAC 12- 006.09(I) Based on observations, interviews, and record reviews; the facility failed to ensure fall interventions were being implemented to prevent falls for 1 resident (Resident 17) and ensure safety during wheelchair locomotion with the use of footrests to prevent the potential for injury for 1 resident (Resident 13). The sample size was 3. The facility identified a census of 31. Findings are: A. A record review of a facility policy Fall Prevention and Response Policy with a last revised date of October 2022 indicated minimizing the risk for falls included to implement interventions to prevent falls. A record review of an Admission Record indicated the facility admitted Resident 17 on 8/17/2022 with diagnoses of epilepsy and vascular dementia. A record review of Resident 17's quarterly Minimum Data Set (MDS, a comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents) with an Assessment Reference Date (ARD) of 7/9/2024 indicated Resident 17 had severe cognitive impairment. A record review of Resident 17's Care Plan with a last review date of 7/19/2024, under the fall section, indicated Resident 17 had a history of multiple falls. Interventions included to ensure bed was in the lowest position at all times when Resident 17 was in bed. An observation on 8/29/2024 at 12:35 PM revealed Resident 17 had been resting in bed. Resident 17's bed was not in the lowest position. An interview on 8/29/2024 at 12:48 PM with Nurse Aide (NA) - E confirmed the bed was not in the lowest position. B. A record review of an Admission Record indicated the facility admitted Resident 13 on 6/8/2023 with a diagnosis of Alzheimer's disease. A record review of Resident 13's quarterly MDS with an ARD of 8/6/2024 revealed Resident 13 had a Brief Interview for Mental Status score of 3/15, which indicated Resident 13 had severe cognitive impairment. The MDS also revealed Resident 13 required full assistance for wheelchair locomotion. An observation on 8/28/2024 at 2:20 PM revealed NA-F had been pushing Resident 13 in their wheelchair from the commons area down to their room without the use of footrests. An interview on 8/28/2024 at 2:24 with NA-F confirmed NA-F did not use the footrests during locomotion in the wheelchair for Resident 13. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 8/29/2024 at 1:25 PM with the Director of Nursing confirmed the expectation is for staff to use wheelchair footrests when transporting residents in their wheelchairs for safety and to prevent the potential for injury.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49263 Licensure Reference Number 175 NAC 12-006.09(J) Licensure Reference Number 175 NAC 12-006.09(J)(i)(1) Based on observations, record review and interview; the facility staff failed to implement interventions to manage weight loss for 2 (Resident 12 and 21) of 3 sampled residents. The facility staff identified a census of 31. The Findings Are: A. A record review of a facility policy Nutrition Unplanned Weight Loss Clinical Policy with a last revised date of March 2019 revealed a 5% weight loss in one month was significant. Under section Recording Weights and Follow-Up, the policy revealed nursing would notify the MD (the resident's medical provider) of the weight change. The policy also revealed in the Treatment/Management section that the staff and physician would identify pertinent interventions based on identified causes and overall resident condition, prognosis, and treatment wishes. A record review of Resident 21's Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning, dated 8/6/24 revealed that Resident 21 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a prescribed weight loss program. A record review of Resident 21's weights revealed on 7/8/2024, the resident weighed 99.5 pounds and on 8/6/2024, the resident weighed 92 pounds which was a 7.54 % loss in one month. A record review of Resident 21's progress note dated 8/14/24 by the Registered Dietitian (RD) revealed the resident had some weight loss in the prior 30 days, that the resident's current diet seemed to be appropriate, and that the RD recommended to continue with the liquid protein order and with fortifying foods at all meals. A record review of Resident 21's physician's orders revealed the following: -An order dated 11/28/2022 that stated the resident was to receive a consistent carbohydrate diet (CCD) with regular textures and consistency. This order also stated, Fortified Foods Program. -An order dated 3/1/2024 that stated to give the resident 30 milliliters (ML) of Protein Oral Liquid by mouth one time a day. A record review of Resident 21's care plan, which had a last review date of 8/14/2024, revealed the following nutritional interventions: -Provide and serve supplements as ordered: 30 ML of liquid protein 1 time per day. This intervention was dated 8/14/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide, serve diet as ordered. Monitor intake and record every meal. This intervention was dated 8/14/2024. -Current diet ordered: CCD, regular texture, regular consistency. This intervention was dated 11/30/2022. -I want staff to honor my food preferences. This intervention was dated 11/30/2022. -Staff to monitor and record my foods/fluids daily. This intervention was dated 11/30/2022. -Staff will obtain weight as scheduled. This intervention was dated 6/7/2023. An interview on 9/4/24 at 9:05 AM with the Director of Nursing (DON) confirmed that Resident 21's primary provider had not been notified of their significant weight loss and there had been no new interventions put into place to mitigate Resident 21's weight loss. 51122 B. A record review of Resident 12's quarterly MDS) with an Assessment Reference Date of 6/12/24, Section I revealed Resident 12 had diagnoses of Diabetes Mellitus, an open wound on the left lower leg, and lymphedema. A record review of Resident 12's physician orders indicated one order in the Diet category which read, CCD, Consistent Carbohydrate diet Regular texture. A record review of Resident 12's physician orders revealed the following additional orders: - Resident needs to monitor sodium intake every shift, dated 8/5/24. - Resident to follow diabetic diet, dated 6/7/24. - Decrease sodium in diet (no hot dogs, ham, sausage, or bacon), dated 5/29/24. - Diet needs no fruit, sweets, no CARBs (potatoes), no pasta, rice bread. Low sodium and diabetic diet, dated 4/25/24. A record review of Resident 12's document titled, Physician Visit/Communication, dated 8/5/24 from the wound clinic, includes the new order, Resident needs to monitor sodium intake. A record review of Resident 12's care plan last revised 6/7/24 revealed the intervention, Double protein consumption. A record review of Resident 12's physician orders did not reveal a protein supplement order. An interview on 9/03/24 at 3:22 PM with the Dietary Manager (DM) revealed the diet on record for Resident 12 in Dieting Manager, a program used by the kitchen staff to access diet orders was, CCD Consistent carb diet, regular texture. The DM confirmed they were not aware of any other diet orders or recommendations in place for Resident 12. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 08/29/24 at 12:34 PM revealed Resident 12 was in the dining room for lunch. The food served to the resident was mechanical soft stir-fried beef and broccoli with rice and pureed mandarin orange/pineapple mixture. A record review of Resident 12's printed meal ticket for the lunch meal on 8/29/24 indicated Resident 12's diet was CCD consistent carbohydrate, diet texture regular. Supplemental notes on the meal ticket included, no kool-aid, no sauces/gravies; no bread products or breaded meat; no sweets; ground food. An observation on 9/4/24 at 12:25 PM revealed Nurse aide (NA)-C was assisting Resident 12 to eat altered texture beef stroganoff over pasta, ground brussel sprouts, and chocolate ice cream. Ranch dressing was mixed with the stroganoff and vegetable. An interview was conducted with the Director of Nursing (DON) on 9/3/24 at 2:50 PM. During the interview the DON confirmed the additional diet orders for a low sodium diet were ordered by the wound clinic, and the diet served did not match those recommendations. An interview with Nurse Consultant-A (NC-A) on 09/04/24 at 12:20 PM confirmed Resident 12's care plan was not up to date in all areas and did not reflect the resident's current status or dietary recommendations. NC-A confirmed the physician orders from the wound clinic were not reflected in the primary diet order.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49263 Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interview, the facility staff failed to assess 1 (Resident 19) of 2 sampled resident's pain. The facility census was 31. The Findings Are: A record review of facility policy Pain Assessment and Management Policy with revision date of June 2021 revealed pain management is a multidisciplinary care process that includes assessing the potential for pain, effectively recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the pain, developing and implementing approaches to pain management, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions, and modifying approaches as necessary. The policy also states to document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. A record review of Resident 19's Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning, dated 6/18/24 revealed Resident 19 had a Brief Interview for Mental Status (BIMS) score of 10/15, which indicated the resident had moderately impaired cognition. The MDS also revealed Resident 19 had diagnoses of arthritis and hemorrhoids and had been receiving scheduled pain medications as well as non-pharmacological pain interventions. A record review of Resident 19's care plan, which had a last reviewed date of 7/17/2024, revealed Resident 19 had chronic pain related to osteoarthritis (osteoarthritis occurs when the flexible, protective tissue at the ends of bones, called cartilage, wears down). The care plan stated the facility was to monitor and record the resident's pain characteristics: quality (e.g., sharp, burning); severity (1 to 10 scale); anatomical location; onset; duration (e.g., continuous, intermittent); aggravating factors; and relieving factors. A record review of Resident 19's physician's orders, printed on 9/3/24, revealed the following pain-related orders: -An order for Tylenol Extra Strength 500 milligram (MG) tablet, give 1,000 MG three times a day for knee pain. -An order for Voltaren Gel 1 % (a topical non-steroidal anti-inflammatory gel used for pain relief), apply 2 grams (GM) to upper extremities and 4 GM to lower extremities four times a day. -An order for Anusol Cream (a medication used to treat minor pain, itching, swelling, and discomfort due to hemorrhoids), apply to rectum three times a day. -An order of Pain Monitoring: Monitor for verbal and/or non-verbal signs of pain every shift. If the pain scale is scored at 5 or more, complete a pain progress note. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 19's Medication Administration Record (MAR) for June 2024 revealed that Resident 19 had rated their pain at a 5 or greater when the staff conducted their day shift pain monitoring on June 1st, 2nd, 5th, 6th, 11th, 19th, and 29th. A record review of Resident 19's progress notes for the month of June 2024 revealed no evidence of a progress note being documented related to Resident 19's reported pain on June 1st, 2nd, 5th, 6th, 11th, 19th, or 29th and the response to pain management interventions. A record review of Resident 19's MAR for July 2024 revealed that Resident 19 had rated their pain at a 5 or greater when the staff conducted their day shift pain monitoring on July 12th, 14th, 17th, 26th, and 31st. The resident also rated their pain at a 5 or greater during their evening shift pain monitoring on July 31st. A record review of Resident 19's progress notes for the month of July 2024 revealed no evidence of a progress note being documented related to Resident 19's reported pain on July 12th, 14th, 17th, 26th, or 31st and the residents response to pain management interventions. A record review of Resident 19's MAR for August 2024 revealed that Resident 19 had rated their pain at a 5 or greater when the staff conducted their day shift pain monitoring on August 14th, 15th, 23rd, and 28th. A record review of Resident 19's progress notes for the month of August 2024 revealed no evidence of a progress note being documented related to Resident 19's reported pain on August 14th, 15th, 23rd, or 28th and the residents response to pain management interventions. A record review of Resident 19's MAR for September 2024, through the 4th of the month revealed that Resident 19 had rated their pain at a 5 or greater when the staff conducted their day shift pain monitoring on September 3rd. A record review of Resident 19's progress notes for the month of September 2024 revealed no evidence of a progress note being documented related to Resident 19's reported pain on September 3rd and the residents response to pain management interventions. An interview on 9/4/24 at 2:28 PM with Nurse Consultant (NC)-A confirmed that there were no pain progress notes documented for Resident 19 and there was no evidence that Resident 19's complaints of pain that had been identified in the pain monitoring on their MAR during the months of June, July, August, and September 2024 had been assessed or addressed by the facility staff.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49263 Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interviews, the facility failed to assess 1 (Resident 25) of 1 sampled resident's dialysis access port site daily. The facility census was 31. The Findings Are: A record review of a facility policy Dialysis with revision date of March 2019 revealed that the facility was to monitor the resident's access site for signs or infection at least daily. A record review of Resident 25's Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning, dated 5/23/24 revealed Resident 25 had a diagnosis of end stage renal disease and was receiving dialysis (a treatment that removes waste and extra fluid from the blood when the kidneys are no longer functioning properly). A record review of Resident 25's care plan, with a last reviewed date of 8/26/24 revealed Resident 25 was receiving dialysis three times per week. There were no interventions in the care plan related to assessing Resident 25's dialysis port site. A record review of Resident 25's active physician's orders revealed an order stating, Dialysis daily note every Monday, Wednesday and Friday upon return. The order did not specify what information was to be documented in the notes. Record review of Resident 25 medical record that included, Medication Administration Records, Treatment Administration records, Progress Notes and practitioners orders from 8/02/2024 through 9/02/2024 revealed there were no indications the facility staff were monitoring Resident 25's dialysis access site. An interview on 9/3/24 at 4:27 PM with the Director of Nursing (DON) confirmed Resident 25 had a dialysis port site, not a fistula, and revealed the DON expected Resident 25's vital signs and weight to be obtained by facility staff, as well as a progress note that Resident 25 had returned the facility and how (gender) is, upon the resident's return to facility following dialysis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference Number 175 NAC 12-006.12(A)(vi) Based on record review and interview; the facility staff failed follow up on recommendations by the facility pharmacist and failed to obtain the rational for dosage reductions for 4 (Resident 6, 14, 19 and 27) of 5 sampled residents. The facility staff identified a census of 31. Findings are: A. A record review of an Admission Record indicated the facility admitted Resident 6 on 6/17/2022 with diagnoses of Dementia and anxiety. A record review of Resident 6's Progress Notes with a date of 5/31/2024 revealed a monthly medication regimen review completed by the pharmacist with recommendation to check a vitamin D level. A record review of Resident 6's Progress Notes with a date of 3/31/2024 revealed a monthly medication regimen review completed by the pharmacist with a recommendation to recheck a thyroid-stimulating hormone (TSH) level due to a levothyroxine (thyroid medication) dose change on 1/29/2024. A record review of Resident 6's Progress Notes with a date of 2/29/2024 revealed a monthly medication regimen review completed by the pharmacist with a recommendation to consider a gradual dose reduction of Resident 6's olanzapine(a antipsychotic medication). A record review of Resident 6's Progress Notes with a date of 11/30/2023 revealed a monthly medication regimen review completed by the pharmacist with a recommendation to consider a gradual dose reduction of Resident 6's sertraline (a antidepressant medication). A record review of Resident 6's Progress Notes with a date of 10/31/2023 revealed a monthly medication regimen review completed by the pharmacist with recommendation to check a TSH level. An interview on 8/29/2024 at 11:43 AM with the Director of Nursing (DON) revealed the DON had not received any physician responses to recommendation made by the pharmacist during their monthly medication regimen reviews in the last six months the DON had been employed by the facility. An interview on 9/3/2024 at 8:55 AM with Nurse Consultant (NC) - A revealed the facility had no evidence the provider acted upon or had provided rationale for not acting upon pharmacist recommendations made during the monthly medication regimen reviews. 49263 B. A record review of Resident 19's Admission Record revealed Resident 19 was admitted to the facility on [DATE] with admission diagnoses of dementia, vitamin D deficiency, essential (primary) hypertension (elevated blood pressure), and urinary incontinence. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 19's progress note dated 6/30/24 by the pharmacist revealed a recommendation to update the diagnosis on the resident's Potassium medication order from primary hypertension to an appropriate diagnosis. A record review of Resident 19's physician's orders revealed an order for Potassium Chloride Extended Release (ER) capsule, 10 milliequivalents (mEq) once a day for Essential (primary) Hypertension. The order had a start date of 9/6/23. An interview on 8/29/24 at 11:43 AM with the Director of Nursing (DON) revealed the DON had not received any physician responses to recommendations made by the pharmacist during their monthly medication regimen reviews in the prior 6 months. An interview on 9/3/24 at 8:55 AM with Nurse Consultant (NC)-A confirmed the facility had no evidence of Resident 19's provider acting upon or providing rationale for not acting upon pharmacist recommendations made during the monthly medication regimen reviews. C. A record review of Resident 27's Admission Record revealed Resident 27 was admitted to the facility on [DATE] with a primary diagnosis of Parkinsonism (Parkinsonism is a broad term comprising a clinical syndrome and presenting with various neurodegenerative diseases, which manifest with motor symptoms such as rigidity, tremors, bradykinesia, and unstable posture, leading to profound gait impairment). A record review of Resident 27's progress note dated 1/31/24 by the pharmacist revealed a recommendation to discontinue the resident's lisinopril (a medication used to treat elevated blood pressures) due to the resident having repeated hypotension (low blood pressure). A record review of Resident 27's medical records revealed a scanned emergency department visit document. This document revealed Resident 27 was seen in the emergency department on 3/29/24 due to confusion and a low blood pressure and that the resident's lisinopril order was discontinued during this visit. An interview on 8/29/24 at 11:43 AM with the Director of Nursing (DON) revealed the DON had not received any physician responses to recommendations made by the pharmacist during their monthly medication regimen reviews in the prior 6 months. An interview on 9/3/24 at 8:55 AM with Nurse Consultant (NC)-A confirmed the facility had no evidence of Resident 27's provider acting upon or providing rationale for not acting upon pharmacist recommendations made during the monthly medication regimen reviews. 51122 D. A record review of Resident 14's Progress Notes, dated 8/30/2024 revealed a monthly medication regimen review completed by the pharmacist with a recommendation of a gradual dose reduction of the resident's sertraline (an antidepressant medication). A record review of Resident 14's Progress Notes, dated 6/30/2024 revealed a monthly medication regimen review completed by the pharmacist with the statement, Recommend updating labs - cholesterol and A1c. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 14's Progress Notes, dated 5/31/2024 revealed a monthly medication regimen review completed by the pharmacist with the statement, Recommend drawing yearly cholesterol. A record review of Resident 14's Progress Notes, dated 4/30/2024 revealed a monthly medication regimen review completed by the pharmacist with the statement, Recommend checking A1c. A record review of Resident 14's Progress Notes, dated 3/31/2024 revealed a monthly medication regimen review completed by the pharmacist with the statement, Please add diagnosis to Bumex. Interview on 9/3/24 at 8:55 AM with Nurse Consultant-A (NC-A), revealed the facility had no evidence of physician reviews of the monthly medication reviews or GDRs for Resident 14.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49263 Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview; the facility staff failed to follow up on a gradual does reduction (GDR) for psychotropic medications for 2 (Resident 6 and 27) and failed to obtain the rational for the continued use of an as needed (PRN) medication that exceeded 14 days for 2 (Resident 17 and 27) of 5 sampled residents. The facility staff identified a census of 31. The Findings Are: A. A record review of facility policy Antipsychotic Use Policy and Procedure with revision date of November 2022, revealed a policy statement To ensure neuroleptics, hypnotics, sedative, antidepressant, anxiolytic, and antipsychotic medications will be used only when it is necessary to treat a specific condition. The policy also revealed that PRN (as needed) orders for anti-psychotic drugs were to be limited to 14 days and could not be renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication. B. A record review of Resident 27's Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning, dated 7/16/24 revealed that Resident 27 had a Patient Health Questionnaire (PHQ-9), a validated interview that screens for symptoms of depression and provides a standardized severity score and a rating for evidence of a depressive disorder, score of 0/27 which indicated the resident did not have depression, and had diagnoses of parkinsonism, depression, and hallucinations. The MDS also revealed that the resident had been taking antipsychotic, antianxiety, and antidepressant medications and that the physician had not attempted a GDR of their medications. A record review of Resident 27's physician's orders printed on 9-03-2024 revealed the following orders: -Prozac (an antidepressant medication) 40 milligrams (MG) one time a day related to depression. This order had a start date of 5/13/24 and did not have an end date or duration indicated. -Lorazepam (an anxiolytic or anti-anxiety medication) 0.5 MG, give 1 tablet by mouth every 30 minutes as needed for anxiety and give 2 tablets by mouth every 30 minutes as needed for anxiety or shortness of breath. This order had a start date of 6/3/24 and did not have an end date or duration indicated. -Quetiapine Fumarate (Seroquel, an antipsychotic medication) 25 MG tablet, give 12.5 MG every 12 hours as needed for health maintenance related to adjustment disorder with depressed mood. The order also stated to give 12.5 MG at bedtime for health maintenance related to adjustment disorder with depressed mood. This order had a start date of 2/21/24 and did not have an end date or duration indicated. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 27's medical records revealed the resident was seen by their primary provider that exceeded 14 days on the following dates: -2/22/24 -3/29/24 -4/24/24 -6/25/24 -8/20/24 A record review of Resident 27's medical records revealed no evidence of a GDR being attempted or rationale for not attempting a GDR for the resident's psychotropic medications, no evidence of a rationale for the continued use of the PRN psychotropic medication beyond 14 days, and no evidence of the resident being re-evaluated every 14 days for the continued use of their PRN antipsychotic medication. An interview on 9/3/24 at 8:55 AM with Nurse Consultant (NC)-A revealed the facility had no evidence of Resident 27's provider attempting a GDR of their psychotropic medications and confirmed there had been no provider visits besides the ones reflected in the resident's medical records. An interview on 9/3/2024 at 1:22 PM with the Advance Practice Registered Nurse (APRN) revealed the APRN saw Resident 27 approximately every 1-2 weeks for Hospice visits but that these visits were not conducted for the purpose of renewing Resident 27's PRN Seroquel prescription. 49766 C. A record review of an Admission Record indicated the facility admitted Resident 17 on 8/19/2021 with diagnoses of delusional disorder, depression, anxiety, and alcohol abuse. A record review of Resident 17's Order Summary with a date of 9/3/2024 revealed an order for PRN Ativan with a start date of 5/3/2024. The order did not include a duration or stop date. A record review of Resident 17's medical record revealed no evidence of physician documentation of a rationale or duration to extend Resident 17's PRN Ativan beyond 14 days. An interview on 9/3/2024 at 8:57 AM with NC-A confirmed the facility had no evidence Resident 17's physician had documented a rationale or duration to extend Resident 17's PRN Ativan beyond 14 days. D. A record review of Resident 6's MDS with a date of 8/6/2024 revealed Resident 6 had a PHQ-9 score of 0/27, which indicated Resident 6 had no current symptoms of depression. The MDS also revealed Resident 6 had been taking an antipsychotic, antianxiety, and antidepressant and that the physician had not attempted a GDR. A record review of Resident 6's Order Summary revealed the following orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bupropion (an antidepressant medication) for anxiety. This order had a start date of 1/18/2023 and did not have an end date or duration indicated. -Olanzapine (an antipsychotic) for Dementia. This order had a start date of 2/21/2023 and did not have an end date or duration indicated. -Sertraline (an antidepressant) for anxiety. This order had a start date of 1/18/2023 and did not have an end date or duration indicated. A record review of Resident 6's medical record revealed no evidence of a GDR being attempted for Resident 6's psychotropic medications. An interview on 9/3/24 at 8:55 AM with Nurse Consultant (NC)-A revealed the facility had no evidence of Resident 6's physician having attempted a GDR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.11(E) Based on observation, interview, and record review; the facility failed to ensure sanitary conditions in the kitchen and that food was used or discarded before their expiration dates to prevent the potential for foodborne illness. This had the potential to affect all 31 residents who ate from the kitchen. The Findings Are: A record review of facility policy Sanitation Inspection with copyright date of 2024 revealed all food service areas would be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies, and other insects. An initial kitchen tour conducted on 8/28/24 at 9:06 AM revealed the following observations: -The metal shelving unit where the metal pots and pans were stored had gray fuzzy matter along the shelves and sides of the unit as well as brown and black debris on the bottom of the unit, just below bottom shelf. -On a shelf above the handwashing sink there was a plastic bin that contained an unopened bottle of PF Chang's Teriyaki sauce with a best by date of 12/5/2023. -On a shelf next to the dishwashing sinks was a bag of biscuits that was dated 8/19. -The stovetop had a large amount of burned/cooked on food debris around all of the burners. -The dishwashing sink had an Ecolab 146 Multi-Quat Sanitizer dispenser which had a tube running from the dispenser into the sink. The end of the tube was resting inside a metal pot that was full of a yellowish liquid and food debris. -The window above the dishwashing sink was open and there was brown and gray debris on the interior windowsill. -There was a rolling cart next to the handwashing sink that had a tray on top of it with 4 Styrofoam bowls with cake slices in them and 5 plastic bowls with peach slices in them. None of the bowls were labeled or dated. -The floor throughout the kitchen had food debris and dried liquid splashes on it. Also, during the initial kitchen tour, the following items were observed in the walk-in refrigerator: -A plastic bag labeled diced onions that was dated 8/16. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A plastic tub labeled [NAME] Soup that was dated 8/14. -A plastic bag labeled turkey breast that was dated 8/14. -A plastic bag labeled chicken breast that was dated 8/19. -A plastic tub labeled marinara that was dated 8/20. -A plastic container labeled Chopped Garlic in Water with a best if used by date of 7/14/24. -A plastic container labeled parmesan cheese that was dated 5/25. A record review of the 2017 Nebraska Food Code revealed in section 3-501.17 that ready-to-eat, time/temperature-controlled foods should be clearly marked to indicate the date or day by which the food should be consumed or discarded, which is a maximum of 7 days. The date of preparation should be counted as day 1. An interview on 8/28/24 at 9:27 AM with the Dietary Manager (DM) revealed that food items were to be used or disposed of within 5 days of opening or preparing and that the bowls of cake and peaches on the rolling cart were not labeled and had been left out from the evening prior. The DM confirmed each of the outdated items identified during the initial kitchen tour. The DM also confirmed the gray fuzzy matter and debris on the shelves, stovetop, and windowsill should have been cleaned and that the Ecolab tube should not have been resting in the pot full of liquid.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49766 Licensure Reference 175 NAC 12-006.18(B) Based on observation, interview, and record review; the facility failed to ensure infection control practices were implemented for oxygen administration for 1 (Resident 6) of 1 sampled residents. The facility identified a census of 31. Findings are: A record review of 1st Class Medical's document The Importance of Changing Your Nasal Cannula with a date of 10/2/2018 indicated to disinfect oxygen nasal cannulas use an alcohol wipe then allow to dry to prevent the potential for bacteria buildup and infections. An observation on 9/3/2024 at 10:24 AM revealed Resident 3 had been ambulating from the dining room and down the hallway to their room. Resident 3 had been dragging their oxygen's nasal cannula on the ground during ambulation, dragging it through food debris and dirt. Further observation s revealed Nurse Aide (NA)-C intervened and placed the nasal cannula back in Resident 3's nose without first disinfecting it. An interview on 9/3/2024 at 10:28 with NA-C confirmed NA-C did not sanitize the nasal cannula before applying back into Resident 3's nose and should have.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49263 Based on observation, interview, and record review; the facility failed to ensure there were no flying insects in the kitchen. This had the potential to affect all 31 residents who ate food prepared within the kitchen. The Findings Are: A record review of 2017 Nebraska Food Code, under section 6-501.111 revealed the premise shall be maintained free of insects. A record review of facility policy Pest Control Policy with revision date of March 2019 revealed that the environment would be monitored by facility staff and that there was to be an emphasis on the pest control program in the kitchen. A record review of facility policy Sanitation Inspection with copyright date of 2024 revealed that all food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies, and other insects. An observation on 9/3/24 at 9:54 AM in the kitchen revealed 4 insects flying around in the kitchen. The insects were observed landing on and walking on the steamtable, food prep counter, and other various surfaces in the kitchen. An observation on 9/3/24 at 12:02 PM revealed 3 insects flying around the steamtable, which contained foods that were to be served to the residents, and landing on the resident meal plates and steamtable countertop which Cook-N was using for cutting sandwiches in half. An interview on 9/3/24 at 1:00 PM with Cook-N confirmed there had been flying insects in the kitchen throughout that day. Cook-N stated the facility normally sprayed an industrial bug killer at night but that Cook-N wasn't sure it was being used each night and the flying insects had been worse over the previous couple of days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285150	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest View Care Center	420 Gordon Avenue Chadron, NE 69337

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 49766 Licensure Reference 175 NAC 12-006.04(B)(i) Based on record reviews and an interview, the facility failed to ensure five out of five sampled employees had completed initial orientation as required. This had the potential to affect all residents who resided at the facility. The facility identified a census of 31. Findings are: A record review of the Facility Assessment with a last updated date of 5/19/2024, under Section 3.4 Staff training/education and competencies, revealed training will be completed at orientation and refers to the orientation check list. A record review of Nurse Aide (NA) - G's personnel record provided by the facility revealed no evidence initial orientation had been completed. A record review of Licensed Practical Nurse (LPN) - H's personnel record provided by the facility revealed no evidence initial orientation had been completed. A record review of NA-I's personnel record provided by the facility revealed no evidence initial orientation had been completed. A record review of Registered Nurse (RN) - B's personnel record provided by the facility revealed no evidence initial orientation had been completed. A record review of NA-J's personnel record provided by the facility revealed no evidence initial orientation had been completed. An interview on 9/4/2024 at 11:30 AM with the Administrator revealed the facility did not have evidence initial orientation had been completed for NA-G, LPN-H, NA-I, RN-B, or NA-J.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285150	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest View Care Center	420 Gordon Avenue Chadron, NE 69337

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49766 Licensure Reference 175 NAC 12-006.04(B)(ii)(1) Based on record reviews and an interview, the facility failed to ensure 12 hours of continuing education had been completed for 3 of 5 sampled employees. This had the potential to affect all residents who resided at the facility. The facility identified a census of 31. Findings are: A record review of the Facility Assessment with a last updated date of 5/19/2024 indicated continuing competence of nurse aides of at lest 12 hours per year is to be completed. A record review of a Course Completion History for Nurse Aide (NA) - K revealed a total of 3.85 training hours. A record review of a Course Completion History for Medication Aide (MA) - L revealed a total of 11.85 training hours. A record review of a Course Completion History for MA-M revealed a total of 9.1 training hours. A record review of a facility provided employee listing revealed NA-K was hired on 5/22/23, MA-L was hired on 9/9/22, and MA-M was hired on 9/1/22. An interview on 9/4/2024 at 9:55 An with the Administrator confirmed NA-K, MA-L, and MA-M had not met the required 12 hour of training per year.