DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 10/5/17 Complaint # 70898-C was investigated and not substantiated. Complaint # 69204-C was investigated and substantiated. The following deficiency relates to the investigation. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000	See attached POC.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Georgelet RN-BC, LNHA — TITLE: Administrator — (X6) DATE: 10-27-17

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.

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1	F 323		

by:
Based on observation, record review, and interviews with resident, family and staff, the facility failed to ensure each resident received adequate supervision to prevent accidents. Concerns were noted for two of four residents (Residents # 3 & #4) that sustained falls with injuries. Resident #3's care plan revealed the resident required staff assistance for transfers and walking; and the resident used the call light to alert staff when she needed assistance with walking and transfers. On 8/31/17, Resident #3 sustained a fractured arm when she attempted to self transfer without alerting staff that she needed assistance. Observation revealed Resident #3 displayed short term memory loss and lacked the cognitive skills and ability to consistently use the call light as demonstrated by her fall history. Record review revealed Resident # 4 had several unwitnessed falls (both in her room and in the dining room) with care plan interventions not followed and or not updated to provide adequate supervision. The facility reported a census of 55 residents.

Findings include:

1. According to documentation in the medical record, Resident # 3 had diagnoses which included Alzheimer's disease, Parkinson's disease, history of a fracture femur and muscle weakness. The facility Minimum Data Set (MDS) assessment dated 07-03-2017 indicated Resident #3 scored 14 (of 15) on the Brief Interview for Mental Status (BIMS) indicating no cognitive decline. The assessment form also indicated Resident # 3 required extensive staff assistance with activities of daily living including bed mobility, transferring, ambulation in and out of the room,

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 dressing, toilet use and bathing. Resident #3 required limited staff assistance with personal hygiene and was able to eat independently. The care plan dated 7/11/17 identified Resident #3 resided in a secured unit due to her Parkinson ' s and Alzheimer ' s diagnoses; and she had previously lived outside the memory care unit however she did not thrive. Resident #3 walked with a scissors like gait and staff were to encourage her to keep her head up and feet strait. Resident #3 required one staff assistance when walking, and required staff assistance with bed transfers, and transfers to/from the toilet. The facility developed plan of care for Resident #3 revised date of 07-11-2017 identified the risk of falls related to Parkinson's disease, Alzheimer's disease and arthritis. The interventions included the following: * blue pressure relieving mattress to bed * call light is within reach and encourage the resident to use * inspect skin daily for redness, report to doctor as needed (prn) * lotion to arms everyday and PRN * signs posted in room to remind resident to please ask for help, use call light. The care plan revealed Resident #3 needed staff to provided assistance to identify precipitating factors(s)/stressors and she needed staff assistance to identify potential problems and solutions. Resident #3 ' s care plan for communication revealed she had impaired cognitive functioning/dementia or impaired thought processes due to short term memory loss, Alzheimer ' s. Staff were directed to monitor/document/report as needed changes in cognitive function, specifically changes in	F 323		

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3	F 323		

decision making ability, memory, recall and general awareness and mental status.

A review of the interdisciplinary progress notes dated 6-6-17 at 10:30 p.m., revealed staff went to Resident # 3 ' s room to apply treatment to the resident ' s right ankle and found the resident sitting on the floor.

According to the facility "incident/accident report" dated 06-06-2017, Resident #3 slid from the bed while tying her shoes at 10:30 p.m. Resident #3 did not sustain an injury. The incident report identified a new intervention of placing a floor mat next to the bed. This new intervention was not added to Resident #3's plan of care.

The facility "incident/accident report" dated 08-09-2017 indicated a CNA heard a thud [sound] and went to the resident ' s room. Staff found Resident #3 on the floor in front of the recliner at 1:45 p.m. Resident #3 did not sustain an injury. The incident report identified a new intervention of added dicem (sic) to the recliner. The plan of care also indicated staff applied skid strips in front of the recliner.

The facility "incident/accident report" dated 08-19-2017 indicated the nurse was called to the resident ' s room by CNA for an unwitnessed fall. Staff found Resident #3 on the floor with his/her back against the bed at 8:30 p.m. Resident #3 sustained a skin tear to his/her right hand "pinky" finger. The incident report and plan of care identified a new intervention of adding skid strips in front of the bed.

A late entry documented on 8/21/17 in the interdisciplinary progress notes revealed the fall

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 on 8/19/17 noted the resident reported she had been walking backyards to sit on the bed, stumbled and missed the bed. Staff revealed they reminded the resident to call for assistance to walk, use the bathroom, go to bed, etc. A interdisciplinary progress notes dated 8-21-17 revealed a new order for urinalysis [to determine if the resident had a urinary tract infection(UTI)] due to recent falls and increase in confusion. On 8-24-17, Resident #3 started an antibiotic for urinary tract infection (UTI). According to the interdisciplinary progress notes dated 8-31-17 at 8:40 p.m., Resident #3 did not use her call light to alert staff as documented by : [staff] heard a loud noise and found Resident #3 sitting on the floor. The resident stated she went to get a water pitcher and stood up and fell. The facility "incident/accident report" dated 08-31-2017 indicated staff found Resident #3 on the floor near the dresser with his/her walker nearby at 8:40 p.m.. Staff completed and documented an assessment and indicated new interventions as: 15 minute checks, "neuro's", sent to ER (emergency room) monitor for pain, remove dresser from the room. According to documentation in the interdisciplinary progress notes on 08-31-2017 at 8:40 p.m. Resident #3 sustained a spiral fracture of the right humerus. The nurse's notes dated 9-4-17 to 9-14-17 documented the resident's arm was splinted and due to swelling, surgery would occur on 9-12-17. The notes revealed on 9/14/17 at 9 a.m., Resident #3 left for right arm surgery and returned on 9/14/17.	F 323		

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 Observation/Interview on 10/4/17 at 8:58 a.m. revealed Resident #3 responded slowly and stated she knew she wasn ' t [suppose] to get up unassisted but could not/did not explain why she still did not wait for help. Resident #3 stated she had gotten up unassisted before and had fallen, but this was the first time she had broken a bone. Resident #3 talked about being frustrated but had trouble finishing her thoughts. According to documentation in the individual plan of care the only interventions added to prevent Resident #3 from falling again included: * 09-08-2017- Bilateral AFO's (ankle-foot orthotics) to feet for ankles * 09-14-2017- sling to R (sic) at all times * 09-11-17- hold AFO's until refitted. During an interview on 10-04-2017 at 10:50 a.m. the facility Administrator indicated on/or about 06-06-2017, a floor mat had been implemented but later (unknown date) it was discontinued due to potentially being a increased hazard for Resident #3 to fall. The Administrator also indicated that Resident #3 had been treated for several urinary tract infections during June, July and August. She also acknowledged that Resident #3 scored a "14" on the BIMS, and at times was quite alert, but at other times not so alert and oriented. During the survey investigation on 10-03-2017 through 10-04-2017 no additional interventions were added to prevent Resident #3 from getting up unassisted and potentially falling again. 2. According to documentation in the medical record, Resident #4 had diagnoses which	F 323		

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 included right artificial hip joint, diabetes, depression and dementia. The facility MDS dated 08-28-2017 indicated Resident #4 scored 3 (of 15) points on the BIMS indicating severe cognitive decline. The assessment form also indicated Resident #4 required extensive staff assistance with activities of daily living including bed mobility, transferring, ambulation in the room, dressing, toilet use, personal hygiene and bathing. Resident #4 was able to eat independently. The facility developed plan of care for Resident #4 initiated on 03-15-2017 and revised on 06-15-2017 identified Resident #4 at "HIGH" risk for falls related to confusion, Alzheimer's disease, psychoactive drug use and poor decision making skills. Interventions included the following: * be sure call light is within reach and encourage to use it for assistance as needed. Try to anticipate his/her needs if you are able. * call light attached to arm of recliner when in chair * gripper strips in front of rocker in her room * PT (physical therapy) evaluate and treat as ordered or PRN (as needed) * signs placed in room to use call light for assistance as a reminder and visual aide related to cognition fluctuations. The facility "incident/accident report" dated 03-19-2017 indicated Resident #4 was observed up independently in the dining room and as staff responded, Resident #4 fell before staff arrived. The incident report indicated new interventions were added of not leaving Resident #4 in the dining room unattended and Resident #4 was to be the last Resident to come into the dining room and the first to leave the dining room.	F 323		

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 The facility "incident/accident report" dated 04-18-2017 indicated staff found on the floor at 3:10 a.m. with his/her legs pointed toward the recliner and his/her head under the bed. The report indicated Resident #4 was alert to self only and added the intervention of keeping the call light attached to the arm of the recliner when in the chair. The facility "incident/accident report" dated 05-31-2017 at 8:00 p.m. indicated staff found Resident #4 in the doorway of his/her room on his/her left side and complaining of pain in his/her left arm. The intervention added was to utilize a fall mat on the left side of the bed when Resident #4 is in bed. Resident #4 was transferred to the hospital and returned later with a diagnosis of a fractured humerus (shoulder). The Emergency Department documentation revealed Resident #4 sustained a closed comminuted fracture of right humerus. The facility "incident/accident reports" indicated an unwitnessed fall on 6/9/17 when the aide found Resident #4 sitting on the mat by her bed; the resident was not injured. The intervention listed: discuss room change with resident ' s son. The facility "incident/accident reports" indicated an unwitnessed fall on 7/8/17 when Resident #4 was walking with her wheelchair unassisted and sat down before staff could reach her. The intervention listed: remove from dining room when done eating; and staff member must be in dining room with resident. The facility "incident/accident reports" indicated an unwitnessed fall on 7/18/17 at 7:05 p.m. when	F 323		

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 staff found Resident #4 sitting on the floor not injured next to her recliner chair. The intervention listed: one on one when restless and 15 minute checks. The facility "incident/accident reports" indicated a fall on 7/19/17 at 9:00 a.m. revealed Resident #4 restless [during] 1-1 in activity. The resident stood and fell to the floor hitting her head. Staff revealed the resident should not be left alone during activity. The interventions dated 7-19-2017 revealed neuro's and not to be left alone during activity. The facility "incident/accident reports" indicated Resident #4 continued to fall on 07/21/2017, and 08/03/2017; and 08-21-2017 as documented in the nurses notes). According to documentation in the resident's plan of care, the following interventions were added as follows: **07-21-2017- not to be left in room alone in wheelchair. *08-03-2017- neuro's per protocol; continue with current interventions. *08-03-2017- dycem on wheelchair *08-21-2017- sent to emergency room; continue with 15 minute checks and visual checks. According to an entry in the nurse's notes dated 06-12-2017 at 10:00 a.m., staff suggested moving Resident #4 to the memory care unit and family declined and instead requested a bed alarm to implemented. The notation indicated a bed alarm was ordered. An entry in the nurse's notes dated 07-18-2017 at 7:05 p.m. indicated staff would "find a chair alarm tomorrow". During an interview on 10-04-2017 at 9:19 a.m.	F 323		

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 _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & REHAB	2401 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 the facility Administrator responded to these entries and stated the facility did not use bed/chair alarms, but did have a sensor alarm on the wall. Resident #4 ' s care plan documented the sensor alarm initiated on 6/15/17 faced along bed frame and was turned on when the resident was in bed. The sensor alarm was changed to "on at all times when the resident was in room alone" on 7/19/17. During the survey investigation 10-03-2017 through 10-04-2017 no further interventions were put in place to ensure Resident #4 did not get up unassisted and/ or fall. During an interview on 10-03-2017 at 4:10 p.m. a family member of Resident #4 indicated that staff seem to implement interventions to prevent falls, "after the fact".	F 323		

Crestview Nursing & Rehabilitation

Plan of Correction

October 27, 2017

Preparation and execution of this plan of correction doesn't constitute admission or agreement of the deficiencies cited but is submitted because it is required by state and federal law.

F323

Date of correction: October 4, 2017

1. In respect to Resident #3, Resident #4, and all other residents, our nurses and MDS coordinator have been educated on interventions to implement to prevent falls.

2. The facility's Quality Assurance Program, through the monitoring of the Director of Nursing and Quality Improvement Committee, will monitor compliance on a monthly basis for three months then quarterly.

This constitutes our credible allegation of compliance as of October 4, 2017.