STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165516	A. BUILDING _____ B. WING _____	C 03/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTRIDGE CARE CENTER	1015 WESLEY DRIVE MAQUOKETA, IA 52060

(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 OK ✓ Correction date 3/16/21 PAO Facility reported incident #96019-I and complaints #95161-C and #96018-C were investigated from 2/24 - 3/3/3021 and were substantiated with the following deficiencies. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Total residents: 49	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including	F 622		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: LNHA (X6) DATE: 3/16/21

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.

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F 622	Continued From page 1 Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-	F 622		

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F 622	Continued From page 2 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility policies, the facility discharged one of four residents reviewed (Resident #2) without appropriate documentation in the resident's medical record. Facility census was forty-nine (49) residents. Findings include: The Minimum Data Set (MDS) dated 12/17/2020 revealed Resident #1 discharged with a return anticipated and diagnoses included anxiety, diabetes and chronic pulmonary (lung) disease. The Transfer/Discharge Report dated 12/17/2020 revealed Resident #2 transferred from the facility	F 622		

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F 622	Continued From page 3 to the hospital emergency department due to difficult and labored breathing. The resident's Discharge Plan signed 11/4/2020 revealed the resident admitted to the facility on 8/7/2020 due to inability to care for self and the resident had no plan to discharge at that time. The Care Plan documented the resident used a cane for ambulation, a wheel chair for distance and required oxygen constantly. On 12/17/2020 the physician ordered the facility to transfer the resident to the hospital via ambulance due to difficulty breathing and pain and pressure in the lungs. Progress Notes included: a. 12/17/2020 at 4:10 P.M., resident complained of difficulty breathing at rest with minimal exertion and a racing heart. Verbal order received from physician to send to the hospital. b. 12/18/2020 at 3:41 P.M., received phone call from hospital social worker stating resident treated for pulmonary embolism, high blood sugar and Covid-19 positive. Probably discharge from hospital and return to facility on Tuesday, December 22. c. 12/22/2020 at 12:12 P.M., received phone call from hospital, nurse requesting information related to Covid-19 positive date confirmed. Stated resident recovered. Nurse shared the resident underwent a thoracentesis (procedure where needle is inserted between lung and chest wall) and removed 1,200 milliliters (ml) of fluid. Stated patient currently worked with therapy and would possibly return next week. Nurse shared the physician conducted a work up for possible lymphoma (cancer). d. 1/7/2021 at 11:53 A.M., received call from	F 622		

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F 622	Continued From page 4 hospital to update plan and return to facility. Resident, diagnosed with lymphoma had a Pleurx (lung) catheter placed on 01/06 and needed management upon return. Resident opted for treatment and requires numerous follow up appointments with oncologist and pulmonary provider. Call placed to insurance regarding the cost of equipment regarding the Pleurx, and informed insurance would not cover the cost under the resident's level of care. Call placed to care coordinator at hospital and informed care coordinator that facility could not meet resident's needs at this time. Hospital Transition Planning documentation included: a. 12/18/2020 at 11:00 A.M., Staff G, Registered Nurse (RN), Care Coordinator documented the resident's Covid test remained positive and patient planned to return to nursing home for long term care on discharge. b. 12/31/2020 at 3:01 P.M., Staff G documented she spoke to Staff H, RN at the facility who stated they could provide the patient with her cares. During admission, Staff G spoke to hospital staff and assured them the facility could handle the medical needs of the patient. Discharge plan is to return the patient to the facility. c. 01/01/2021 at 12:56 P.M., physician discussed examination with patient and discussed management of Pleurx catheter. Discussed potential risks, benefits, side effects, goals and alternatives to plan of care. Resident signed consent but spoke to nursing home Staff A, DON, and they escalated matter to corporate. They cannot say if they can manage the patient's care with the catheter based on policies and competencies. Will address Pleurx when Staff A calls back on Monday.	F 622		

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F 622	Continued From page 5 d. 01/08/2021 at 1:08 P.M., Staff G documented patient ready for discharge since 01/06/2021. Staff G updated the facility on the patient's progress and needs at discharge for the past two weeks. Patient had new diagnosis of lymphoma, prior to insertion of Pleurx catheter Staff G verified with facility they could manage the care. After speaking with administration, Staff A reported she investigated the catheter and they could provide the aftercare. Because of the facilities response, the patient decided to have the catheter inserted. Staff G verified with the facility they would be able to provide transportation to the appointments. Staff G learned the Pleurx drainage bottles cost $1,300.00 for a case of ten and the facility indicated they could not afford it. The drain required emptying once a week so the case would last ten weeks. Staff G received permission to supply the facility a month worth of drainage bottles. Staff G also offered to help with scheduling follow up appointments. Staff G received a call from Staff A who informed Staff G the facility would not allow the resident to return. The facility Discharge/Transfer of the Resident policy included: a. Purpose: To provide safe departure from the facility and to provide sufficient aftercare of the resident. b. Transfer: to leave the facility with plans or intentions to return. (i.e. transfer to an acute care facility for appropriate care). Procedure: Point 2. The physician is required to write a discharge order. Point 6. Complete a discharge summary and post discharge plan of care form. Include a list of medications with instructions.	F 622		

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The Admission Agreement signed by Resident #2 on 08/07/2020 included:
Point 2.4) In the even the resident is temporarily absent from the facility for medical treatment or for therapeutic reasons beyond the period allowed by the Department of Human Services and the resident does not hold the bed for the extended absence, the resident shall be readmitted to the facility upon the availability of a Medicaid certified bed providing the resident requires the services of the facility and is eligible for Title XIX assistance.

The Bed Hold Policy signed on 8/7/2020 included:
The state of Iowa will pay the facility for ten days per month to hold the bed while resident is hospitalized. If the stay is longer than 10 days and the resident chooses not to pay to hold the bed, the resident will be discharged on the 11th day.

On 01/24/2021 at 1:36 P.M., Staff A voiced Resident #2 transferred to the hospital for longer than ten days. When the facility re-evaluated her and assessed the Pleurx catheter, the facility felt they could not meet the resident's needs. The catheter required a new tube and suction bottle with each change, and the bottles cost $1,300.00 for six bottles, an expense the facility had to absorb.
Staff A thought possibly in an acute setting the cost would be covered. The resident ended up transferring to another facility from the hospital.
On 03/01/2020 at 2:00 P.M., When asked if the facility had any hospital records, Staff A revealed the facility did receive hospital records but disposed of as the resident did not return.
On 03/02/2021 at 11:00 A.M., Staff A reported the facility had an order to transfer the resident to the

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F 622	Continued From page 7 emergency room. They should have documented in the nurse's notes discharge information regarding medications and belongings. The facility did not treat it as an involuntary discharge, they did not feel they had qualified staff to care for the catheter. Staff A had no other notes regarding the assessment of the resident or communication with the physician regarding re-admission. On 03/02/2021 at 10:15 A.M., Staff H, RN reported working at the facility for two months. Staff H had prior experience working with the Pleurx catheters and indicated the bottle required changing each time it filled with fluid. Staff H currently had an incident that required her to be off work. The hospital offered to pay for supplies and Staff H thought the facility planned to re-admit the resident. Staff can be trained to change the Pleurx system and patients do at times go home with it.	F 622		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy and staff interviews, the facility failed to provide adequate supervision and failed to ensure the resident environment remained as free of accident hazards as is possible for one of four	F 689		

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F 689	Continued From page 8 residents reviewed who fell and sustained burns to the legs from a baseboard heater. The burns required hospitalization, surgical intervention, grafts, a wound vacuum and resulted in pain. (Resident #1) The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) dated 12/16/2020 documented Resident #1 had the ability to sometimes make self understood and understand others, inattention, disorganized thinking and cognitive impairment. The resident required extensive assistance of two staff for bed mobility and to transfer from one surface to another. The MDS indicated the resident did not ambulate, had urinary and bowel incontinence, and diagnoses included: anemia, dementia and anxiety. The resident had a fall since the prior assessment without injury. The Care Plan initiated 8/4/20 revealed Resident #1 used a wheel chair for mobility, a history of falls and self transferring, incontinence, and hard of hearing. The care plan instructed staff to position the bed with one side against wall for safety. The bed contained upper half rails for positioning and for transfer assistance. Staff were to provide transfer assistance back to bed after meals and an antiroll wheel chair with brake extenders. The resident transferred using a mechanical sit to stand lift with staff assistance, a wheel chair for mobility and required incontinence cares. The Physician's Order dated 5/26/2016 included 2 half side rails to assist with bed mobility, positioning, aide in transferring and for boundary	F 689		

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identification.

Progress Notes included:

The resident had Covid 19 and hospitalization from 11/25/2020 - 12/7/2020.

1/6/2021 - at 8:44 p.m. Staff B, LPN (Licensed Practical Nurse) documented staff found the resident on the floor on his/her knees with forehead resting on the floor. Staff assessed the resident and found no injuries and assisted him/her to bed with three staff. Prior to the fall, the resident sat in the wheel chair by bedside table for supper.

1/20/2021 - at 3:38 p.m. Staff found the resident sitting next to the bed on his/her bottom on the floor. Staff assisted the resident to bed approximately 15 minutes prior and last observed him in bed 10 minutes prior to sliding out of bed. Staff placed a fall mat next to the bed.

2/16/2021 - at 5:27 p.m. Staff C, LPN documented the resident self propelled the wheel chair to the dining room and staff found him with knees and elbows on the ground in front of the wheel chair. Staff observed the resident's buttocks almost in the chair. The resident sustained an abrasion to the forehead that measured 4.5 centimeters (cm) X 3.5 cm. Staff assisted the resident back to the wheel chair using a Hoyer lift. The resident did not sustain other injuries and staff notified the physician.

2/20/2021 - at 2:00 a.m., Staff B, LPN documented staff entered the resident's room and found him laying against the baseboard heater. Staff assisted the resident back to bed

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F 689	Continued From page 10 with two staff and noted a large burn to the right knee to ankle and left knee. The physician directed staff to transfer the resident to the Emergency Department (ED) for evaluation. At 2:20 a.m, the ambulance arrived and transported the resident to the hospital. 2/22/2021 - University of Iowa Health Center informed the facility the resident required a feeding tube placed for nutritional support to aid in recovery. The Incident Report dated 2/20/2021 at 2:00 o'clock a.m. and prepared by Staff B, LPN included: Nursing description: Found resident on floor next to bed, right leg resting on heater and left knee pushed against corner of heater. Resident incontinent of bowel and bladder. Resident unable to give description. Injury Type: Burn left knee, front and right lower leg, front. Predisposing Environmental Factors: None Predisposing Physiological Factors: Confused and incontinent. Incident occurred in the resident's room with no witness to the event. Resident #1's 2/20/2021 Hospital ED Notes included: A complete history is unavailable secondary due to dementia. The last known normal was 2/19/2021 at 11:00 p.m. The patient, not able to provide any substantive history whatsoever, has significant dementia. Information came from Emergency Medical Services (EMS), and the nursing home. Somewhere between 11:00 P.M. and midnight, staff observed the patient, and patient doing fine. Thirty minutes prior to the ED	F 689		

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arrival, staff discovered the patient fell off the bed and landed on a space heater. Total duration of time there is unknown.
Assume the patient is in significant pain but cannot communicate well.
Skin: Warm, dry, intact, patient has approximately 5% superficial partial burns on the medial (middle) aspect of the right leg. 20% of that is above the knee on the right with the rest below the knee on the medial tib-fib (tibia fibula bones in lower leg) area. There is already some blistering and desquamation (skin peeling) of skin. The area of involvement is on the medial aspect of the right leg. On the left leg, the medial aspect of the knee. There is approximately 0.75% deep partial burn through the epidermis (outer layer of the skin) and the dermis (layer underneath the epidermis) into the adipose (fat) tissue.
The physician consulted the University of Iowa Hospital Burn Unit and Resident #1 transferred to the Burn Unit.

The University of Iowa Health Care Progress Notes dated 2/23/2021 included:
Admit Date: 2/20/2021
History of Present Illness:
80 year old who sustained a 5 - 10% body surface area contact burn on left lower extremity and right lower extremity on 2/20/2021, unknown time but after 11 P.M. on 2/19/2021 at the nursing home while he presumably slipped out of bed and landed with his bilateral lower extremities on a space heater. The resident is nonverbal and unable to tell us what happened.
Extremities: Right lower extremity with about 2-3% total body surface area superficial to partial deep partial burns extending from medial distal thigh to shin anteriorly, mostly blanching. Left lower extremity, medial prepatellar (in front of

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F 689	Continued From page 12 the knee cap), with deep partial burn 1%. 2/24/2021 - Burn excision/debridement (removal of damaged tissue) under general anesthesia with or without skin graft. A feeding tube was placed while patient under general anesthesia. 3/1/2021 - Burn excision/ debridement, wound vac (to assist with healing) placement and skin graft under general anesthesia. On 2/24/2021 at 9:00 a.m., Staff D, Administrator reported Resident #1 transferred from the facility to a local hospital and then to the University of Iowa hospital. The facility had difficulty reaching the resident's next of kin and had to contact police to assist. The resident had Covid-19 and lost strength but made progress working with therapy. At approximately 2:00 a.m. staff observed the resident on the floor on the left side of the bed near the window. The resident 's left knee landed on the base board heater and the right knee landed on top of it. The resident never yelled out for help. The bed contained "U' bars for side rails and and an alternating air flow mattress. When the resident had an incontinent bowel and bladder episode, the chux (under pad) went with him out of the bed and the blanket remained on the bed. On 2/24/2021 at 9:55 a.m., Staff E, Maintenance checked the Resident's room temperature using an infra-red thermometer. The room temperature read 71.5 Fahrenheit and the baseboard heater temperature, cool to the touch, read 75.2 Fahrenheit. Staff D, Administrator, indicated thermostats were set at mid range, approximately 75 degrees Fahrenheit. Currently the bed sat approximately 16 inches from the wall. Staff D reported the facility moved beds away from the walls, which	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTRIDGE CARE CENTER	1015 WESLEY DRIVE MAQUOKETA, IA 52060

(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 689	Continued From page 13	F 689		

contained baseboard heaters, during winter months for safety. Staff D reported Resident #1 made no recent attempts to self transfer from the bed.

At 1:30 p.m. on 2/24/21, Staff D, Administrator reported the facility followed up with staff working at the time of the incident to ensure they performed frequent rounds. Resident #1 resided on East Hall with a census of 16 residents. The night shift staffed one nurse in the facility from 10 p.m.. until 6 a.m.. and three CNA's (Certified Nurse's Aides), one on each unit. Staff D expected nursing staff to complete resident rounds every two hours and provide incontinence cares if needed. Staff D indicated she currently worked on a plan instructing staff to visually check each resident every thirty minutes.

A report dated 2/20/21 completed by the Administrator, identified the "reasonable conclusion" regarding the incident as: Resident with alternating air mattress slid off the side of the bed without making enough noise to alert staff immediately. His inability to move, resulted in his legs resting against base board heater. Staff did appropriate tasks, completing rounds and assessing residents.

On 2/24/2021 at 1:45 p.m., Staff A, DON (Director of Nursing) revealed she completed the initial investigation when Resident #1 fell from the bed. Staff working at the time of the incident reported they last observed the resident in bed around midnight. Staff found the resident on the floor at approximately 2 o'clock a.m. The resident was incontinent. The resident previously had Covid-19 and suffered from weakness since recovery. The facility pulled beds away from the

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F 689	Continued From page 14	F 689		

walls for safety due to the baseboard heaters. On 3/1/2021 at 11 o'clock a.m., Staff A provided a copy of the education given to staff instructing them to provide residents with hourly checks and toileting or incontinence cares every 2 -3 hours. Staff A also provided a copy of staff education with instructions regarding how to help someone after a fall.

On 2/24/2021 at approximately 2 p.m., Staff B, LPN reported working at the facility for four years on the night shift, from 6 p.m. until 6 a.m. After 9:30 p.m. the facility staffed one nurse for Unit One, Unit Two and the East Hall. The evening of the incident, Staff B checked every resident's room at approximately 10:15 p.m. and observed Resident #1 in a low bed, two half side rails in the up position and two blue boots on bilateral lower extremities. Staff left the television on in the resident's room so they could visualize him during the night. The resident had a habit of hanging his leg out over the side of the bed. The resident resided in the nearest room to the nurse's station without a roommate. At approximately 11 p.m. Staff B observed the resident in bed and Staff B went to assist a resident with bedtime cares. Staff B and Staff F, CNA started doing resident rounds on the opposite side of the hall and ended with Resident #1's room at approximately 2 a.m. Resident #1 slid off the bed, with lower extremities on the baseboard heater and incontinent bowel and bladder. One of the blue boots fell off and the other twisted sideways. Staff B observed the bed approximately 16 - 20 inches from the wall. Staff B unlocked the bed and moved it away from the resident. The room temperature felt comfortable and the heater felt hot to the touch. Staff B and Staff D used a stand up lift to get the resident off the floor and onto the

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F 689	Continued From page 15 bed. Observation showed the right leg contained blisters from the inside of the knee down to the ankle and the left knee contained an approximately three inch area that appeared indented where it pressed into the corner of the heater. The resident's blanket remained on the bed but the chux pad fell from the bed along with the resident. Staff B reported the resident had no prior similar incidents. On 2/24/2021 at 12:30 p.m., Staff F, CNA reported working for an agency and worked three shifts at the facility, with two of the shifts on East Hall. Between midnight and 1 a.m., Staff F answered a call light and observed Resident #1 in bed. At 1 a.m. Staff F and Staff B started resident rounds and provided incontinence cares per their usual routine. When they arrived at Resident #1's room at approximately 2:15 a.m., they observed the resident on the floor, in between the bed and wall, and laying on the heater. The resident had bowel and bladder incontinence. Staff F did not recall if the hand rail had been up or if the resident wore his blue boots. They assisted the resident to bed using the stand up lift. The resident did not use the call light and rarely spoke. After they transferred the resident to the bed, the resident said "right there" and pointed to his legs. Staff F let the resident know they called 911. The resident appeared in pain. The right knee contained an indentation as if it laid on a corner of the heater and the left knee from the inner shin to upper knee contained blisters and raw areas. Staff F's written statement provided to the facility after the incident, revealed Staff F observed all residents in bed at midnight and she and Staff B began rounds at 1:00 a.m.	F 689		

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A 3/1/21 hospital procedure note identified the procedure performed as an OR (operating room) case: burn excision/debridement (major over 5% TBSA (total body surface area)) with split thickness skin graft to right lower leg and burn excision/debridement (minor less than 5% TBSA) without split thickness skin graft and wound vac placement. The burn wound physician performed the procedure under general anesthesia. The split thickness skin for grafting was harvested from the right thigh.

On 2/24/2021 at 2:45 p.m.., Staff E, Maintenance reported working at the facility for one year. Every room contained baseboard heat. Staff E started logging facility temperatures a couple of weeks prior when the outside temperatures were low. No resident ever complained and the inside temperature never dropped below 68 degrees Fahrenheit. Resident room thermostats are set at approximately 72 degrees Fahrenheit unless they request it be turned up. They moved all the beds away from the walls for safety. The facility had no baseboard heaters without covers. When Staff E learned of the incident involving Resident #1 he checked to be sure all beds were 18 inches away from the wall, and they were.

The climatologist reported the temperature on 2/20/2021 at 1:00 a.m. at negative 9 degrees Fahrenheit.
On 2/24/2021 with heat turned up, a probe thermometer read 127 degrees Fahrenheit when placed on a baseboard heater. The heater felt hot to the touch.

A facility form provided from Staff A, DON revealed staff instructions for East Unit:
Round times must be done every two hours, no

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F 689	Continued From page 17 exceptions, no skipping rounds. Round times: 11:30, 2:00 and 4:00 A.M. Staff education provided by Staff A on 03/01/2021 included: a. Please ensure that you are visually seeing each resident hourly and continue to complete toileting, repositioning and incontinence cares every 2 - 3 hours. b. Review of how to help someone up after falling: Only stand a resident with the assistance of two and a gait belt if the resident is able to transfer/ambulate independently or with a gait belt and one person. If there is a potential for injury or they cannot bear weight on at least one leg and usually require the use of a mechanical lift or two persons, a Hoyer lift must be used.	F 689		

F622 Crestridge Inc. reasonably ensures that treatments/interventions are in place to ensure that when the facility transfers or discharges a resident under any of the circumstances specified in paragraph (c)(1)(i)(A) through (F) of this section, the facility will ensure that the transfer or discharge is documented in the residents medical record and appropriate information's communicated to the receiving health care institution or provider, including the basis for the transfer per paragraph (c)(1)(i)(A) of the section, the residents need(s) that cannot be met, facility attempts to meet the resident's needs, and the service available at the receiving facility to meet the need(s).

- R # 2, resident no longer resides at facility

- Like-residents will have proper documentation in the medical records upon discharge

  Documentation will include the basis for the transfer per paragraph (c)(1)(i)(A) of the section of the residents need(s) that cannot be met.

- On 3-6-21 and ongoing a training for all nurses, DON, ADON and MDS Coordinator on discharge documentation

- The Administrator or designee will complete weekly audits for residents that have transferred or discharged

  An audit will be conducted for 12 weeks and then at that time results will be reviewed by QA committee for compliance and further determination of action plan.

- Correction Date: 3.16.2021

Crestridge Inc. Plan of Correction
Self-Report and Complaint survey 2/24/2021-3/3/2021

This plan of correction constitutes our credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State laws.

F689 Crestridge Inc. reasonably ensures that treatments/interventions are in place to ensure that each residents receives adequate supervision and assistance devices to prevent accidents and that the resident environment remains as free of accident hazards as is possible.

- R #1 resident reassessed, moved sides of room so resident is no longer by a baseboard heater
- At risk residents with little or no mobility moved away from baseboard heater.

  Developed a new rounds schedule with all resident safety noted once per hour

- On 3.16.2021 and ongoing a training for Certified Nursing Assistances, nurses, DON, ADON, MDS Coordinator on the following; round times and safety assurance checks

  On 3.16.2021 and ongoing a training with the DON, ADON, Social Worker Designees, MDS Coordinator and infection preventionists with safety meetings

- The Administrator or designee will complete weekly safety audits for residents by baseboard heaters

  The audit will be conducted for 12 weeks and then at that time results will be reviewed by QA committee for compliance or further determination of action plan.

- Correction Date: 3.16.2021