STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165287	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Specialty Care	451 West Orange Street West Branch, IA 52358

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 20331 Based on observation and resident and staff interviews, the facility failed to respect personal property and possessions when they searched the resident's room without consent for one of three residents reviewed. (Resident #3). The facility reported a census of 54 residents. Findings include: The MDS (Minimum Data Set) assessment tool dated 6/14/2024 revealed Resident #3 had no cognitive impairment, transferred from one surface to another independently, used a wheel chair for mobility and had diagnoses including post-polio syndrome, rheumatoid arthritis, and paraplegia. On 9/4/2024 at 1:00 p.m., the resident self transferred from the commode to the nearby bed and sat upright with the support of pillows. The resident described a situation where staff searched her room without her consent while she was not present. Staff left her belongings unorganized and she could tell someone had gone through them. Staff told the resident they were looking for her roommate's television remote, and they failed to find it. On 9/3/2024 at 1:40 p.m., Staff A, ADON (Assistant Director of Nursing) reported the resident reported staff went through her belongings. Her roommate's remote was missing, the resident had a physician's appointment and staff went through her things without her knowledge. Staff were educated after the incident and told the resident had to know and give permission for them to search belongings. On 9/3/2024 at 10:50 a.m. and 1:30 p.m., Staff B, DON (Director of Nursing) reported she instructed staff not to go through resident's belongings without their knowledge. The resident's roommate had things come up missing like the remote and staff searched the resident's side of the room. When Staff B learned of it, she educated staff. The facility's Resident Rights policy revised December 2016 included: Resident Rights Policy Statement Employees shall treat all residents with kindness, respect, and dignity. (continued on next page)

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence. b. be treated with respect, kindness, and dignity. c. be free from abuse, neglect, misappropriation of property, and exploitation.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20331 Based on clinical record review, staff interviews, and facility policy review, the facility failed to administer medication as the physician ordered for one of three residents reviewed. (Resident #2). Findings include: The MDS (Minimum Data Set) dated 6/25/2024 revealed Resident #2 had no cognitive impairment. The MDS dated [DATE] revealed the resident had mild cognitive impairment. The MDS reported the resident had diagnoses including acute congestive heart failure, chronic kidney disease stage III, atrial fibrillation, and pneumonia. The resident's Care Plan revealed the resident had altered respiratory status and used oxygen, initiated 6/19/2024. The Care Plan directed staff to administer medication/puffers as ordered. Monitor for effectiveness and side effects. Monitor for signs and symptoms of respiratory distress and report to physician as needed: increased respirations; decreased pulse oximetry; increased heart rate (tachycardia); restlessness; diaphoresis; headaches; lethargy; confusion; empty (coughing up blood); cough; pleuritic pain (pain in the chest with inhale or exhale); accessory muscle usage; skin color changes to blue/gray. Resident #2 admitted to the ED (emergency department) on 7/29/2024 with shortness of breath. The ED noted indicated he had Acute hypoxic (low oxygen levels) respiratory failure. He discharged back to the facility on [DATE] with the following new physician orders: albuterol sulfate 90 mcg (micrograms), 2 puffs inhalation every 6 hours as needed; Prednisone 60 mg (milligrams) oral daily; Tiotropium bromide (Spiriva Respimat) 2.5 mcg, 2 puffs inhalation daily. The resident also received an order for furosemide (diuretic) 40 mg oral daily, 40 mg oral every morning, for a total of 80 mg (your normal dose is 40, this is in addition for 5 days only). The resident's Progress Notes included: Effective Date: 07/29/2024 12:18 New order to send resident out to University of Iowa ED to be evaluated due to a change in condition including abnormal vital signs and edema. 7/30/2024 - late entry: Staff D at 12:00 - Resident returned from the hospital with new orders to start Albuterol, prednisone, Spiriva Respimat. Not Notified. 8/1/2024 - Nurse Practitioner. Resident has not received new medications from 7/30/2024: prednisone, albuterol nebulizer, Spiriva, increased furosemide. Very dysgenic (SOB), lethargic and without breathing treatments and prednisone since readmission. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	This 80 y.o. male was seen today in follow up of his recent hospitalization . He was sent out on 7/29 for decreased oxygenation, decreased BP, increased work of breathing,worsening edema. He had adjustments to his furosemide over the past week without any improvement. He returned to the branch the next day with new orders for albuterol nebs, Spiriva, prednisone and increased furosemide. Today, nursing reports his new orders have not been entered into computer and he hasn't been getting the prednisone or breathing treatments since readmission. He is very dyspneic, lethargic and his oxygen saturations are low to mid 80's. He will be sent back out as he is at maximum 5 L per NC of O2 and oxygen sats still low at 84%. Plan: COPD (Chronic Obstructive Pulmonary Disease) exacerbation: Was given Duonebs with improvement in the ED; Orders for albuterol, Spiriva and prednisone burst ordered upon discharge from the ED. Has not had since coming back, which could account for the worsening of his exacerbation. Discharge back to hospital. On 8/6/2024 the resident readmitted to the facility. On 8/10/2024 the resident discharged from the facility and returned to the hospital with decreased oxygen saturation levels and increased lethargy. The resident passed away at the hospital on 8/11/2024. The Medication Error Incident Report dated 8/1/2024 prepared by Staff D, former DON (Director of Nursing) included: Resident was sent to the hospital for SOB and exacerbation of COPD. Resident was sent back with new medications. Medication was not entered into the eMAR (electronic Medication Administration Record) by the staff nurse. Resident is unable to recall events. The medication error was found by the regional nurse, and the physician was notified. The charge nurse and DON were educated. The Summary of alleged incident included: Date of incident: 8/1/2024. Date of investigation: 8/2/2024. Resident returned from the hospital for new medication orders to start. These orders were not put into the system and resident did not receive his medications. Resident was sent back to the hospital and that is when it was realized that he never received his new medications from his last hospital visit. Root Cause Analysis: New orders were not put into PCC (Point Click Care) upon resident's readmission back to the facility from the hospital. Conclusion: Patient was re-hospitalized . The facility Past Non-Compliance Checklist included: (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Plan of Correction: Education provided to nursing staff, charge nurse responsible to complete on any admission or transfer in from the hospital followed by double noting by two nurses. The EMS (Emergency Medical Services) report dated 8/1/02024 at 3:14 p.m. included: Arrived with patient upright in bed, complained of SOB (shortness of breath) that started early this morning. Lungs are coarse bilaterally, oxygen on at 5 liters via nasal canula, normally the patient is on 3 liters. Oxygen saturation levels running at about 88% since SOB started this morning. Patient states care center has been giving him puffs but won't let him use nebulizer. Feels fluid buildup in his legs has increased since he has been back at care center. Patient requested to have nebulizer treatment. Nebulizer Albuterol 2.5 mixed with Ipratropium 0.5 mg. given. Patient reports feeling better with initial dose but still SOB. Nebulizer given times two, transported to hospital. The hospital discharge summary dated 8/6/2024 included: Reason for Admission: Shortness of Breath (Started today. Given his inhaler at care center. 85% for EMS. Given nebulizer by EMS. Now 90 % on 3 L (liters). Normally uses 3 L at Crestview.) Hospital Course - In short, this is a [AGE] year-old male who presents to the hospital with acute on chronic respiratory failure secondary to restrictive lung disease/interstitial lung disease and sleep apnea. Patient was started on prednisone, oxygen supplementation and breathing treatments. Patient also was started on IV (intravenous) Lasix (diuretic). This did improve patient's respiratory status that he is now at baseline. He is now ready to be discharged back to his skilled nursing facility with a Medrol Dosepak (steroid). Family also requested that we stop his anticoagulant as he is a risk factor for falls. This has been accommodated. Patient stable to be discharged . Principal Diagnosis (definitive condition responsible for the admission): Acute hypoxic on chronic hypercapnic (too much carbon dioxide in your blood), respiratory failure (HCC). The Death Certificate filed 8/21/2024 included: Time of death: 8/11/2024 at 4:25 a.m. Immediate cause of death: Acute on chronic hypoxic and hypercapnic respiratory failure. On 9/4/2024 at 8:30 a.m., Staff F, physician reported the resident missed medications and that resulted in him returning to the hospital, but it did not result in his death. On 8/10/2024 when the resident returned to the hospital in ICU (Intensive Care Unit), he made the decision to withdraw cares. He had acute and chronic respiratory failure but they probably could have brought him around. His primary diagnosis of pulmonary arterial hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart) combined with heart failure and lung disease caused him to have real problems. Since it was his choice to withdraw treatment, we cannot say it was his demise. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 9/4/2024 at approximately 9:00 a.m., Staff D (former DON) reported working as the director of nursing from April until August 21, 2024. When Resident #2 returned from the hospital on 7/30/2024, Staff E, agency nurse gave the re-admission papers to Staff D. Staff E failed to put the new orders in the system. Staff D placed the admission papers in her office and exited the building due to feeling ill. On 7/30/2024, Staff A texted Staff D and informed her the resident's new orders had not been entered into the system. Staff D instructed her to call the hospital and physician to get the resident's records. On 8/1/2024, the corporate regional nurse caught the error and questioned Staff D, and indicated the resident had to return to the hospital. The facility had to file a self report with the state. On 8/16/2024 Staff D received a written warning that included: Resident admitted with new orders that were not placed in resident's orders creating a significant medication error. The ADON (Assistant Director of Nursing) reached out to you for guidance. She was told to reach out to the hospital for a copy of orders that were in your office which could have been accessed more timely, which would have been in the best interest of the resident. This instance resulted in a self report. On 9/4/2024 at 9:30 a.m., Staff E, RN (Registered Nurse) reported he worked for an agency. On 7/30/2024 Resident #2 returned from the hospital around noon. Staff E assisted the paramedics transfer the resident to his bed. Staff E handed the resident's admission paperwork to Staff D and Staff D said thank you. The resident arrived during a busy time and Staff E had no time to enter the medication orders into the system. Staff E indicated it was Staff D's responsibility to handle the admission. On 9/3/2023 at 2 p.m., Staff A, ADON reported working on 7/30/2024. Around 7:30 p.m. Staff A noticed the resident had a couple of new medications delivered. Another nurse, Staff G reported the resident had not been readmitted into the system. Staff A notified Staff D that the resident had been admitted with no orders. Staff D revealed the orders were locked in her office, and that afternoon she had to leave work as she was feeling ill. Staff A called the hospital but they were unable to provide the orders as the resident's records had been sent to medical records. The resident failed to receive the new medications. The facility policy Administering Medications revised April 2019 included: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions; and c. Honoring resident choices and preferences, consistent with his or her care plan. 6. Medications errors are documented, reported, and reviewed by the QAPI (Quality Assurance and Performance Improvement) committee to inform process changes and or the need for additional staff training. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns. 9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. Checking photograph attached to medical record; and b. If necessary, verifying resident identification with other facility personnel. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.