STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165463	A. BUILDING _____ B. WING _____	**09/17/2020**

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

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents. (Resident #8) The facility failed to follow interventions and provide appropriate interventions and increased supervision of Resident #8 who had a history of [REDACTED]. The facility had no plan in place to increase supervision and kept the resident's room door closed due to quarantine. The fall investigation identified staff last toileted the resident 3 hours and 15 minutes prior to the 7/7/20 fall and staff last saw the resident 2 hours and 15 minutes prior to the fall in a recliner until the resident got up per self as physical therapy applied PPE outside her room immediately prior to the fall. The investigation form revealed the resident said she attempted to self transfer from recliner to the bed. The form did not identify how long the resident sat in the recliner prior to the fall. The baseline care plan directed staff to toilet every 2 hours and did not address the resident's transfer/ambulation needs. A shift report form dated night shift 7/6/20 did not identify they toileted the resident. They identified the resident as wet. The 7/7/20 fall resulted in a fractured forearm. The resident fell again on 7/16/20 at 5:15 a.m. following self transfer in an attempt to get to the toilet. The resident activated the call light but did not wait for assistance. The shift report for that date was blank and did not identify any care provided to the resident that night. The fall investigation form revealed the resident was incontinent at 2:15 a.m. (3 hours prior to fall) The investigation form did not identify when staff last saw the resident. The care plan in place 7/16/20 did not contain toileting interventions even though the resident was frequently incontinent and did not identify the resident's transfer and ambulation needs or that the resident attempted to self transfer and did not reliably use the call light. The 7/16/20 fall resulted in subdural hematoma and death. The facility census was forty-eight (48) residents. Findings include: An Admission Minimum Data Set (MDS) with observation end date of 7/7/20 revealed Resident #8 admitted to the facility 7/1/20. The MDS assessed the resident with a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The resident required extensive assistance of 1 staff for bed mobility, transfers, ambulation in room, ambulation off unit, dressing, toilet use, and personal hygiene. A balance during transition and walking test coded the resident as not steady- only able to stabilize with staff assistance in all areas of testing. The resident had no functional limitations in range of motion in the upper or lower extremities. The resident utilized a walker and wheelchair. The resident was frequently incontinent of bladder and occasionally incontinent of bowel. The resident had [DIAGNOSES REDACTED]. The MDS identified a fall history with a fall in the last 2-6 months prior to admission. The MDS coded falls since admission - one with injury (except major). Medication received during MDS look back period included: anticoagulants taken 7 of 7 days. A Nurse Practitioner note dated 7/1/20 documented a history of falls for the resident. The resident was a [AGE] year old female with a history of Alzheimer's, [MEDICAL CONDITION] fib and hypertension who (prior to coming to the facility) lived in independent living but had issues with recurrent falls and generalized weakness so moved in with a family member for short period of time and now is at facility for therapy and long term care. A Fall assessment dated [DATE] scored the resident with a score of 10. The assessment revealed a score of 10 or greater as a high risk for falls. The fall assessment identified the resident as disoriented times 3 at all times. The resident was chair bound and/or assist with elimination. The resident was unable to perform a balance test. A Baseline care plan dated 7/1/20 coded yes to cognitive loss. Bowel and bladder coded yes with assistance needed for toileting. The baseline care plan identified the resident required assistance of 1 staff with toileting. Interventions listed under bowel and bladder included: offer toileting every 2 hours, check and change every 2 hours as needed, and keep call light within reach and encourage use. Anticoagulant use coded as yes with listed [DIAGNOSES REDACTED]. Fall risk coded yes as prior history of falls. Interventions listed under fall risk included call light within reach and non skid footwear. The baseline care plan did not identify the resident's transfer/ambulation needs or need for ambulation assistance devices. Fall 7/7/20 Fractured Right Forearm: A fall scene investigation report identified a fall occurred 7/7/20 at 8:45 a.m. and revealed the resident self transferred and fell sustaining a 1 centimeter (cm.) by 2.5 cm. laceration to the right forearm. Staff last toileted the resident at 5:30 a.m. (3 hours and 15 minutes prior to fall) and last observed the resident at 6:30 a.m. in the recliner (2 hours and 15 minutes prior to fall). The resident did not use the call light and stated she attempted to get to the bed. An x-ray on 7/9/20 revealed a fracture to the right forearm. The intervention following the incident was: walker to be within reach at all times. The conclusion/fall team meeting notes identified the facility educated the resident on call light and calling for help (ineffective due to the resident's cognitive status) and a reminder sign on walker and walker in reach. (as of 7/9/20 unable to use right extremity for walker). The shift change report check off for 7/6/20 10 p.m. to 7/7/20 6 a.m. contained the documentation wet with no time listed. The form did not have any documentation listed in the area last toileted/checked/changed. A Skilled Nursing assessment dated [DATE] at 10:28 a.m. documented the resident ambulated with assist of 1 and front wheeled walker but knees buckle at times and she needs reassurance. Resident states she is scared to fall. Progress notes dated 7/8/20 at 8:34 a.m. identified a 12 cm. by 7 cm. dark purple bruise to the right hip related to the 7/7/20 fall. Progress notes dated 7/9/20 at 10:19 a.m. revealed the facility notified the physician of the right wrist bruised, painful and swollen with complaints of pain to light touch. The physician ordered an x-ray for the wrist. On the same date at 1:20 p.m. progress notes identified a 13 cm. by 12 cm. bruise to the upper right arm and 5 cm. by 2.5 cm. bruise to the right shoulder also related to the fall. At 2:04 p.m. the physician also added an order for [REDACTED]. The resident fell and landed on her right shoulder. Complains of pain in her entire right arm, unable to localize. The physician identified the right hand with 3 plus [MEDICAL CONDITION], finger range of motion (ROM) limited on flexion, right wrist 2 plus [MEDICAL CONDITION] with ROM limited on extension, forearm tender, elbow tender with limited extension and right shoulder tender with limited ROM. The [DIAGNOSES REDACTED]. A Major Injury Determination Form for the 7/7/20 fall revealed the resident sustained [REDACTED]. The Nurse Practitioner identified the fracture as not a major injury. Progress Notes dated 7/9/20 at 8:35 p.m. indicated the resident transferred to the emergency room (ER) for evaluation via ambulance. Progress Notes dated 7/9/20 at 11:55 p.m. noted the resident returned to the facility with [DIAGNOSES REDACTED]. Progress notes dated 7/10/20 at 7:11 a.m. identified the resident in pain as evidenced by constantly grimacing, wincing and moaning due to pain in the right arm and new onset of pain in the right leg. No medications were given for pain last night. When in bed the resident constantly moved while grimacing and wincing due to confusion she could not verbalize ain and continued to move saying she planned to get up. Tylenol ([MEDICATION NAME]) no longer effective. On the same date at 11:24 a.m. the physician ordered [MEDICATION NAME] (narcotic) 50 milligrams (mg) every 6 hours as needed and wear immobilizer and brace at all times. A physician encounter note dated 7/13/20 at 6:41 p.m. revealed the resident's pain was controlled with [MEDICATION NAME] (narcotic) and swelling was decreased. The facility should continue with immobilization of the right

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

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) forearm with wrist splint and shoulder immobilizer to keep elbow at 90 degree angle. Repeat x-ray in 7 to 10 days. A Care Plan with initiation date of 7/7/20 noted a focus area of risk for falling due to weakness and confusion. Interventions included: assure call light within reach and make sure room is free of clutter and pathways clear dated 7/7/20; keep walker within reach and reminder sign placed on walker dated 7/7/20. The care plan did not address a toileting plan even though the admission MDS identified the resident as frequently incontinent of bladder and occasionally of bowel. The care plan did not address transfer and ambulation assistance needs. There were no interventions that identified staff increased supervision of the resident. Fall 7/16/20 Subdural Hematoma: A fall scene investigation report dated 7/16/20 at 5:15 a.m. revealed the resident attempted to self transfer to the toilet and fell . The floor had urine on it. Staff last toileted the resident at 2:15 a.m. and the resident was incontinent at that time. The fall huddle findings revealed the resident had to go to the bathroom and pulled the call light but did not wait for staff. The resident possibly slipped in urine while self transferring. Progress notes dated 7/16/20 at 5:15 a.m. revealed the resident sustained [REDACTED]. each. The investigation report identified the facility later noticed a bruise on the right side of the head at 12:10 p.m. The shift change report check off for 7/15/20 10 p.m. to 7/16/20 6 a.m. contained no documentation. The form did not have any documentation listed in the area last toileted/checked/changed. Progress Notes dated 7/16/20 at 7:53 a.m. (after the fall) documented resident and all belongings moved to room [ROOM NUMBER]. A Skilled Nursing assessment dated [DATE] at 9 a.m. revealed the resident ambulated with the assistance of 2 staff pivot transfers related to altered mental status. The resident did fall at 5:15 a.m. and continues with neuros. Change in mental status noted however. Night nurse reported this was how she acted last night. Resident appears restless- wanting to get up but doesn't know what she wants to do. The resident declines pain from fall; increased incontinence noted and the resident did complain of flank pain; urine sample and lab work pending. Will continue to monitor. Progress Notes dated 7/16/20 at 12:05 p.m. documented resident appeared to have a 9 cm x 6 cm bruise/hematoma to right side of forehead-area was not observed during shower this am. Resident unable to declare pain but is extremely restless. Nurse Practitioner aware during telehealth and resident sent to ER to rule out [MEDICAL CONDITION]. Likely the forearm fracture was reinjured during fall. Progress Notes dated 7/16/20 at 3:03 p.m. revealed the resident returned from ER with [DIAGNOSES REDACTED]. Stop [MEDICATION NAME] (blood thinner) and follow up with provider in 1 to 2 days. A Major Injury Determination Form regarding the 7/16/20 fall documented subdural hematoma and contained an electronic physician signature and deemed the injury as a major injury. Progress notes dated 7/17/20 at 7 a.m. revealed the hematoma to the right side of the head measured 11 cm. by 8 cm. dark purple. The resident denied pain but moans. Progress Note dated 7/17/20 at 10:40 a.m. documented an order to repeat the right forearm x-ray in 4 weeks and keep splint on for 6 weeks. Progress Notes dated 7/17/20 at 1 p.m. revealed 2 staff transferred the resident to the bathroom and the resident's left elbow hit the grab bar. The resident obtained 2 skin tears on top of a previous skin tear that originally measured 3 cm. by 1 cm The skin tears measured 3 cm. by 0.1 cm. and 1 cm. by 1.2 cm A physician encounter note dated 7/17/20 at 2:49 p.m. documented the resident fell and sustained a subdural hematoma with a 4 mm (millimeter) shift; family chose not to pursue aggressive treatment and the resident transferred back to the facility. The resident had a hematoma to the right scalp and ecchymosis to the right face. X-rays showed no reinjury of wrist fracture. CT head or brain without contrast dated 7/16/20 at 1:30 p.m. completed due to fall with head injury, altered mental status and on [MEDICATION NAME] (blood thinner). The exam revealed: 1. Subdural hematoma along the right posterior frontal and right anterior parietal lobes with mild midline shift to the left measuring 3.9 mm. 2. Small posterior right frontal scalp hematoma. 3. No evidence of acute fracture. ER information concerning a subdural hematoma identified it as a collection of blood between the brain and its outer covering (dura). As the amount of blood increases, pressure builds in the brain. The condition is caused by bleeding from a broken blood vessel. In most cases the blood vessel ruptures due to head injury, such as from a hard, direct hit. Head injuries can happen in falls. The risk of the condition increases and is more likely to develop in older people, people who take blood thinners and have head injuries. The information revealed a person should get help right away if they take blood thinners and fall and experience minor trauma to the head. Care plan Interventions after the fall of 7/16/20 included to move Resident #8 to a room across from nurses station for more supervision, winged mattress, bed in low position while occupied, toilet/ check and change on rounds at night, ER visit dated 7/16/20. Focus area of bladder incontinence noted with interventions of assist to toilet per request and offer and assist to toilet when waking in the morning, before and after meals, at bedtime, and on rounds and as needed dated 7/17/20. Focus area of activities of daily living (ADLs) noted fracture right ulna. Shift change check off sheet updates added included, right arm brace at all times, toilet during evening rounds, bed in low position when occupied, and winged mattress date 7/17/20. Staff Interviews: On 9/15/20 at 10:53 a.m. Staff A, Licensed Practical Nurse (LPN) stated she worked with the resident when the resident fell on [DATE] at 8:45 am. Staff A stated the physical therapist PT just peeked in on her 30 seconds prior to the fall and the resident sat in the recliner. As PT applied their personal protective equipment (PPE), they heard a thud. Staff A was in the hall and ran down to her room. The resident stated she wanted to get back to bed and fell on her right side, unwitnessed. She didn't know if she hit her head so staff initiated neurological (neuro) checks. Staff A stayed with the resident for the first hour and conducted neuro checks every 15 minutes times 4, 30 minutes times 4, 1 hour times 2 and then every shift for 3 days. Staff A stated all current interventions were in place. The floor was dry, free of clutter, shoes on and call light in reach. Range of motion within normal limits The new intervention was to have her walker within reach. Staff A also worked when the second fall occurred on 7/16/20 at 6 a.m., just shortly after her fall at 5:15 a.m. When Staff A viewed the resident at 6 a.m., she sat in her recliner, alert and oriented to self and appeared restless. The overnight nurse started neuros. Staff S stated all interventions were in place, and identified the new interventions as moving the resident to a room across from the nurses station, winged mattress, bed in low position, and check and change on rounds. Staff A gave the resident a bath around 7:30 am and did not observe a hematoma to the head. Blood work and x-rays were completed. The resident transferred to ER later in the day after the Nurse Practitioner saw the resident and ordered a CT scan. The resident returned to facility a few hours later. Her [MEDICATION NAME] was discontinued at that time. She didn't have any further falls after the one on 7/16/20. On 9/16/20 at 9:25 am, Staff A LPN identified the resident as 50/50 with call light use. The resident required the assistance of 1 staff from the day of admission. Sometimes the resident would wait for assistance and sometimes staff would find her standing in her room with her walker. Staff would redirect and remind the resident to wait for assistance. On 9/16/20 at 8:50 a.m. Staff C, PT Assistant revealed working with Resident 3 times prior to fall on 7/7/20. Staff C stated the resident sat in her recliner and staff informed the resident they would put on the PPE and come in her room. Staff then heard a thud and yelled for the nurse who was in the hallway. The nurse went to the resident right away. Staff C did not go in the room that day. On 7/6/20 the resident ambulated 50 feet with her walker and contact guard assist of 1. According to the resident's speech therapy notes, the resident answered prompts regarding the call button with 60% accuracy and moderate verbal cues. On 9/16/20 at 1:45 p.m. Staff E, Registered Nurse (RN) revealed she did not recall if the resident was a 1 or 2 person assist when admitted since she worked overnights and did not do her assessment. Staff E stated the resident required 1 assist at times and other times 2 person assist. Some days she was stronger than others. Staff E recalled the morning of the 7/16/20 fall. They used 2 staff to get her up after the fall. Staff E did not recall the resident hitting her head but but felt pretty sure she had a skin tear to her right arm or elbow. The resident did use the call light at times and again sometimes the resident could act impulsively and get up on her own. Staff did try to watch her closely as she varied so much with her tracking and wasn't consistent. On 9/16/20 at 11:45 a.m. Staff B, CNA (certified nurse aide) stated the resident required the assistance of 1 staff from the day she admitted to the facility. She was in quarantine as she was a new admission. The resident would get up by herself and not always wait for staff to assist her. One time, Staff B found the resident standing by the air conditioner. The resident did not activate her call light. Staff B guessed the resident activated her call light about 50% of the time. Staff B stated they look at the shift report. Staff B identified shift report as a piece of paper they get at the start of the shift that contains care directives of the residents. After the resident's first fall, Staff B checked on her more often, especially since she was on quarantine with the door closed. Staff B recalled the fall on 7/7/20. PT were getting their gowns on and heard her fall. The fall occurred around breakfast and Staff B didn't recall if the resident activated her call button or not. On 9/16/20 at 12:15 p.m. the Director of Nursing (DON) revealed the resident required the assistance of 1 from the day of admission. The resident's daughter informed them the resident fell at home and needed more assistance. The resident demonstrated to the DON on admission how to use the call button. The resident would not always wait for staff to assist her once she activated the call button for help. The DON stated she makes 10 copies or so of the baseline care plan or shift report and staff get a copy when they start their shift for instructions on how to care for the residents. The DON makes changes and writes down any new interventions and then prints new updated copies for the staff. The DON expects all nursing

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) staff to follow the care plan and ask questions if unsure. On 9/16/20 at 12:40 p.m. Staff D, Certified Medication Aid (CMA) revealed she only knew the resident after her fall on 7/16/20 when they moved her to 400 hall. At that time the resident required 2 staff and a hoyer lift for transfers. The resident could not use the call light when she moved her to her new room on the 400 hall. She had no falls after the one on 7/16/20. On 9/16/20 at 3:07 pm Staff F CNA revealed she thought the resident was a 1 person assist when she admitted to the facility. Staff F stated she never caught the resident up without assistance. Staff F stated the resident used the call button appropriately when she worked. Staff receives report when the arrive and they look at the shift change sheets printed out that contains information needed to take care of the residents, or staff asks questions. On 9/16/20 at 4:35 p.m. Staff G, CMA (certified medication aide) revealed that on admission the resident was a 1 person assist with ambulation. The resident was known to self transfer without using her call button. Staff G found the resident on the toilet before when Staff G passed pills. Staff G stated the resident did use her call button but typically she would try things on her own before using the call button. Staff knows what to do for residents by a shift report that contains all the information on how to take care of the residents. On 9/17/20 at 10:20 am the Administrator revealed she did not know what staff could have added or done differently after the 7/7/20 fall. The resident was in a 14 day quarantine and the facility was told residents in quarantine had to be in a certain area and her area was not close to the nurses station. The Administrator stated they were told this by the Iowa Health Care Association. The Administrator stated she felt staff did everything appropriately. A death certificate identified the resident's date and time of death as 8/12/20 at 4:35 p.m. The manner of death was: accident. A description of the accident injury documented as: fell at care center and struck right side of her head, scan at ER showed subdural with midline shift. The immediate cause of death: [MEDICAL CONDITION] due to or as a consequence of aspiration pneumonia of 7 days, due to or as a consequence of chronic [MEDICATION NAME] use of 27 days underlying cause subdural hematoma of 27 days.