STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165299	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTVIEW ACRES	**1485 GRAND MARION, IA 52302**

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews and observations the facilty failed to maintain [MEDICAL CONDITION] (Continuous Positive Airway Pressure) equipment in a clean and sanitary manner for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 80 on 8/10/2020 prior to their evacuation of all residents on 8/11/20 due to severe storm damage to the facility. Findings include: According to the Minimum Data Set ((MDS) dated [DATE], Resident #1 had [DIAGNOSES REDACTED]. The resident required extensive assistance of 2 staff for transfers, dressing and hygiene. The resident utilized oxygen daily. The resident's Brief Interview for Mental Status (BIMS) revealed the resident with a score of 13 which indicates the resident is alert and oriented. Resident #1 had an admission date of [DATE] to the facility. The resident transferred to another facility on 8/11/20 as a result of a whole facility evacuation due to severe storm damage at the facility. Review of the resident's electronic physician's orders [REDACTED]. During the Admission Assessment the resident complained of chronic shortness of breath and requested assistance from the staff to place the [MEDICAL CONDITION] machine on at that time. Observation on 8/18/2020 at 1:05 p.m., revealed the resident in bed with his head up, [MEDICAL CONDITION] in place with oxygen at 3.5 liters per his [MEDICAL CONDITION]. Observation of the tubing from the [MEDICAL CONDITION] machine to the resident's face revealed a brownish colored tubing with darker sediment noted inside the entire length of the tubing. An interview at this time regarding the cleaning and tubing changes of the [MEDICAL CONDITION] revealed the resident does not think anyone has ever cleaned his [MEDICAL CONDITION] prior to his transfer on 8/11/20 and reports he does not recall ever getting new tubing or [MEDICAL CONDITION] equipment while at the previous facility. During an interview with the Nurse Manager from the previous facility on 8/20/20 at 3:30 p.m., the Nurse Manager stated she managed the care for Resident #1. The nurse stated several weeks ago she found out Resident #1 did not have any [MEDICAL CONDITION] supplies and was working to find out who the provider for the supplies was. The Nurse Manager stated she just hadn't had time to take care of it and then the storm happened. During an interview on 8/19/20 at 2:58 p.m., the Director of Nursing (DON) at the current facility stated when Resident #1 arrived to their facility for admission his [MEDICAL CONDITION] tubing had pink slim inside, he arrived without any extra [MEDICAL CONDITION] equipment . The DON stated she cleaned the tubing immediately and worked on attempting to find who the provider of the [MEDICAL CONDITION] equipment was and to obtain new equipment. During an interview with the [MEDICAL CONDITION] clinic who provided the equipment for Resident #1 on 8/24/20 at 2:00 p.m., the staff at the clinic stated they are the prescriber and provider for Resident #1's [MEDICAL CONDITION] and equipment. Review of their records revealed they last sent equipment to the resident on 9/5/2018 at the previous facility. The clinic staff reported they just recently sent equipment to the resident on 8/13/2020 to his new facility in another city.

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