

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Creston Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Cottonwood Drive Creston, IA 50801	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and policy review the facility failed to provide services meeting profession standards for 1 of 3 residents (Resident #2). The facility failed to follow physician orders for provision of medications as per physician orders. The facility had a census of 54. Findings include: Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating normal cognition. The document provided the diagnoses of atrial fibrillation, anemia, heart failure, hypertension, and respiratory failure. The document listed Resident #2's medications included an anticoagulant. The Care Plan Dated 10/7/25 provided a focus area related to risk for urinary tract infection (UTI) related to incontinence dated 9/18/24 and revised 10/3/24. Interventions included encouraging fluids and monitoring for signs and symptoms of UTIs. An anticoagulant use related to congestive heart failure (CHF) initiated on 3/31/23 and revised 8/26/23 focus area provided an intervention for staff including monitoring for side effects (unusual bruising, bleeding gums, purpura and changes in mental status) initiated 3/29/23. Resident #2's Medication Administration Record (MAR) - Treatment Administration Record (TAR) 9/25 revealed Apixaban Oral Tablet 5 mg, give 1 tablet by mouth 2 times/day (BID) related to chronic diastolic CHF with a start date of 3/29/23, hold date from 9/4/25 to 9/5/25 and hold from 9/5/25 to 9/8/25. Resident #2's MAR - TAR 10/25 revealed Cranberry Concentrate Capsule 500 mg; give 500 mg by mouth in the morning for UTI prevention with a start date of 6/28/25. The Electronic Medical Record (EMR) Progress Notes revealed the following documentation: 9/4/25 12:34 PM note entered by Staff B, Licensed Practical Nurse (LPN), - Certified Nurse Assistant (CNA) alerted the nurse to blood in the resident's brief in the morning. Monitoring revealed continued blood in brief and bedpan with the provider contacted who ordered a straight catheter. Entered 9/4/25 4:50 PM note entered by the Director of Nursing (DON) - duplicate medication brought to the attention of the DON. Audit showed potential for duplication related to the facility not utilizing calendar date system for popping medications, multiple short stock medication cards present at the same time. Unable to verify if duplicate doses administered. The provider was notified and ordered to hold Eliquis in the evening. 9/4/25 entry by provider - the resident was seen for gross hematuria in her brief in the morning. Staff noted the resident received 2 extra doses of Eliquis which is suspected cause of gross hematuria. Urinalysis performed on 9/4/25 revealing red color, turbid clarity, negative bilirubin, negative ketones, large amounts of blood, negative nitrites, and trace leukocytes. Hold Eliquis if no further bleeding may restart at 5 mg BID. 9/5/25 1:47 PM note by Staff B - resident with mouth swelling, redness, pain and discomfort. Bleeding stopped overnight and presented a new issue. Contacted the provider and ordered to send to the emergency department (ED). 9/5/25 1:50 PM note by Staff B - call to the ED potential of double dosing Eliquis on 9/2 and 9/3, previous day's symptoms and complaints today of headache, pain, tingling on R side of face lip swollen on R side. 9/5/25 3:23 PM note by Staff B - the ED reported diagnosis of mouth pain, labs included hemoglobin were good. 9/5/25 7:58 PM - hold Apixaban Oral Tablet 5 mg until seen by the provider on next visit. The facility's Risk assessment dated [DATE] for Medication Error revealed on 9/2 and 9/3 there were 2 Eliquis (Apixaban) medication cards flipped facing forward with both the pills missing for those dates. There was the potential that the resident was given double the dose on 9/2 and 9/3. The document disclosed that facility nurses stated they had been told it didn't matter what date they popped for short stock medications and had not been popping them by calendar date; therefore the DON could not be positive that extra doses had not been given. Observed on 10/9/25 at 8:30 AM Staff D, LPN, provide Resident #2 with medications. The resident received Abilify 5mg, Allopurinol 110 mg, Bumex 2 mg, Claritin 10 mg, Cranberry 450 mg, Ferrous Sulfate 65 Fe), Levothyroxine Sodium 125 mcg, Magnesium Oxide 400 mg, MiraLAX, Potassium Chloride 20 MEQ, Prednisone, Protonix 40 mg, Sertraline 150 mg, Acetaminophen Oral 500 x2, Apixaban 5 mg, Carvedilol 6.25 mg, Rivastigmine 3 mg, Zenpep 40000-126000. The facility failed to provide Resident #2 the correct medication by dispensing Cranberry 450 instead of the ordered Cranberry 500 mg. On 10/8/25 at 1:30 PM Resident #2 stated she had been given too much blood thinner and had a bleeding episode. The resident stated she had been seen by her provider. Resident #2 stated she did not have bleeding past the first day, but did go to the hospital the next day because her face was swollen. The resident did not know how much extra medication she received. On 10/8/25 at 4:31 PM Staff B stated she had been present when Resident #2 had vaginal bleeding. The staff stated everytime the resident had a brief change there had been blood present on that day. Staff B stated the resident had 2 medication cards for</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and policy review the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 3 of 4 residents reviewed (Residents #1, 2 and 4). The facility reported a census of 54. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document listed Resident #1 as occasionally incontinent of bladder. The resident required partial/moderate assistance for transfers and toileting. Resident #1's Care Plan dated 9/29/25 revealed an Activities of Daily Living (ADLs) focus area, dated 7/24/25, with interventions indicating the resident required partial assistance x1, stand pivot transfer, dated 7/24/25 and revised 9/30/25, and parietal assistance x1 for toileting, dated 7/24/25 and revised 9/30/25. The document included a urinary incontinence focus area dated 7/24/25 and revised 7/25/25. Interventions include assistance to the bathroom/commode and perineal cleansing as needed dated 7/24/25. On 10/9/25 at 10:17 AM Resident #1 stated the facility since her admission has had low staffing especially in the afternoons and overnight shifts. The resident stated she has had to wait longer than 15 minutes for assistance with toileting and had episodes of incontinence. The resident stated the incontinence episodes made her very upset. 2. Resident #2's MDS dated [DATE] revealed a BIMS score of 13/15 indicating normal cognition. The document listed the resident as always incontinent of bladder and occasionally incontinent of bowel movements. The resident required total assistance of staff for transfers and toilet hygiene. The Care Plan Dated 10/7/25 provided a focus area related to risk for urinary tract infection (UTI) related to incontinence dated 9/18/24 and revised 10/3/24. Interventions included encouraging fluids and monitoring for signs and symptoms of UTIs. The ADL focus area dated 10/11/23 included interventions of use of a padded Hoyer (dependent mechanical lift) x2 staff for transfers dated 7/31/25, dependent on 2 staff for toileting with use of a bedpan, and partial assistance of 1-2 staff for bed mobility. On 10/8/25 at 1:30 PM Resident #2 stated staffing was worse on the 2-10 shift and has had to wait over 1 1/2 hours to be changed. The resident stated on one occurrence that she had asked staff for assistance to be toileted after lunch and before bingo. The resident stated she watched several staff at the nurses station talking, but no one would assist her with the toileting request. Resident #2 stated she went to bingo in wet pants as she would have been late if they had ever had come to help her and bingo was an activity that was really important to her. Resident #2 stated her personal hygiene was also really important to her and it made her feel terrible that she had to sit in wet pants for 1.5 hours. The resident stated staff have taken an extended period of time for answering her call light leading to bowel incontinence which upsets her. On 10/9/25 at 10:17 AM Resident #1 stated she was present when Resident #2 asked for assistance to complete toileting at the end of lunch and before bingo. Resident #1 stated she also asked staff for assistance on behalf of Resident #2 and no assistance was provided. The resident stated she was aware of Resident #1 having an incontinence episode and having to sit in wet pants during bingo. 3. Resident #4's MDS was in progress due to admission on [DATE]. The electronic health record (EHR) provided Resident #4 had a diagnosis of nondisplaced fracture of the greater trochanter of the right femur with routine healing. The EHR Nursing Admission/readmission Evaluation provided the resident required 1 person assist for transfers and 1 person partial assistance for toileting. The document revealed the resident was alert and oriented to person, place, time and situation. A continuous observation on 10/9/24 began at 7:04 AM with Resident #4's call light turned on. Observed several Certified Nurse Assistants (CNAs), nurse and the Administrator walk past the resident's room with the call light on. At 7:22 AM observed Resident #3 sitting on the edge of the bed and saying someone please help. At 7:26 AM Staff C, CNA, went into the resident's room and the call light was shut off. The call light was on for 22 minutes. A continuous observation on 10/9/25 began at 10:46 AM noting Resident #4's call light was on with auditory beeping heard. Observed several staff standing at the nurses station. The resident's call light went off at 10:50 AM with no staff going in the room. Resident #4 stated the call light had been on for longer than 15 minutes. The resident acknowledged earlier in the day she had called out for help as she needed to use the bathroom and no one had answered her call light. The resident stated the call light had just been on and turned off herself and had a family member assist her as had incontinence episode waiting for staff. The family member confirmed light had been on and staff did not come to assist prior to the incontinence episode. On 10/8/25 at 4:12 PM Staff A, CNA, stated she worked both AM (6-2) and PM (2-10) shifts. The staff stated there had been times where the facility was shorter on</p>		