STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165199	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creston Specialty Care	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, resident interview, staff interviews, clinical record review, and facility policy the facility failed to provide dignity by leaving a trash bag with bandage wrappers on a resident's bed (Resident #54). The facility further failed to provide dignity to Resident #54 by not putting his socks back on and covering his legs. The facility reported a census of 55 residents. Findings Include: Review of the Progress Note in the Electronic Medical Record (EHR) dated 5/31/24 completed by Director of Nursing (DON) revealed Resident #54 scored 14/15 on the Brief Interview for Mental Status (BIMS) indicating the resident is cognitively intact. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 presented upon admission to the facility with 2 stage II pressure ulcers. Observation on 6/18/24 at 11:07 AM revealed Staff D, Licensed Practical Nurse (LPN), place a clean trash bag on Resident #54's bed for completion of dressing change to bilateral feet. Staff D placed the used packaging and adhesive covers of the new bandages in the trash bag. The staff picked up the remaining unused bandages, scissors and left the resident's room at 11:25 AM. The trash bag remained on the bed and the resident's lower legs were uncovered. Observation on 6/18/24 at 11:27 AM Resident #54 turned the call light on. Staff E, Certified Medication Aide (CMA), entered the resident's room at 11:28 AM. The resident requested Staff E bring Staff D back to his room and remove the trash that was left behind. Staff E spoke with Staff D, and returned to the resident's room alone. Staff E entered Resident 54's room, donned the resident's socks, replaced the bedding, and removed the trash. On 6/18/24 at 11:29 AM Staff E stated Resident #54 requested the trash be removed from the bed, his socks to be put back on, and be covered back up. Staff E observed the trash bag on the bed and the resident's feet uncovered. On 6/18/24 at 11:49 AM Resident #54 stated was pissed off that Staff D left his room without replacing his socks, blankets and left the trash on the bed. The resident stated staff have often not covered his lower body following completion of personal cares. Resident #54 revealed he does not feel as though he is being cared for. (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

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 06/20/2024
NAME OF PROVIDER OR SUPPLIER Creston Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Cottonwood Drive Creston, IA 50801	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 1:21 PM the Director of Nursing (DON) stated when changing dressings/applying new dressing the trash bag would be next to the nurse for use. When completed the treatment, the trash bag should be tied up and taken out with the nurse. The facility policy Wound Care revised October 2010 revealed staff should discard disposable items into the designated container. Staff should further reposition the bed covers and ensure the resident is comfortable upon completion.

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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. 46873 Based on clinical record review, observations, family interview, staff interviews and facility policy review, the facility failed to maintain a safe environment due to staff members not following safety precautions during resident transfers, resulting in Resident #21 to have three falls in a three month period. This resulted in harm to Resident #21 due to increasing pain, causing the need for increased pain management, and needing a higher level of assistance for transfers. The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) Assessment of Resident #21, dated 4/23/24 identified a Brief Interview of Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment. The MDS documented the resident required partial assistance of 1 staff member for sitting to standing position, transfers and toileting. The MDS documented a diagnosis of repeated falls. The MDS documented the resident took no scheduled or as needed pain medications during the look back period and had received no non-medication interventions for pain. The MDS documented the resident denied having pain during the lookback period. The MDS coded the resident had experienced one fall in the last quarter. The Care Plan of Resident #21, reviewed 5/3/24 revealed the resident to have a history of falls. The Care Plan directed staff to hold a gait belt (a mobility device worn around the resident's waist to assist caregivers to safely move residents with mobility issues) during transfers. The Care Plan also identified a Focus Area of Activities of Daily Living, which instructed the resident required a partial assist for transfers, dated 11/15/23. On 6/17/24 at 3:55 pm a family member of Resident #21 stated the resident had two recent falls and is now a two person assist. He also stated x-ray results were being waited on as the resident has been complaining of pain since the last fall. The Incident Report dated 3/30/24 documented the resident had a fall at 7:00 am when returning from using the restroom. The Incident Report reflected the staff was not using a gait belt when the fall occurred. Review of the Medication Administration Report (MAR) revealed the resident rated her pain at 0 53 times out of 60 documentation's in the month of April, 2024. She received no as needed acetaminophen for pain during the month of April 2024. The Incident Report dated 5/28/24 documented the resident had a fall at 11:27 pm when being transferred to the bed. The Incident Report reflected the staff had a gait belt on the resident but turned away from the resident momentarily to fix the bed and the resident lost balance and fell to the ground. On 6/19/24 at 12:58 pm, the Director of Nursing (DON) confirmed the Certified Nurse Aide (CNA) had let go of the gait belt during the instance on 5/28/24 when the employee was turning the bed down prior to transferring the resident into the bed. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

The Clinical Physician Orders revealed an order dated 5/29/24 for 2 view x-rays of the left knee.

The X-ray Report signed by the provider on 5/30/24 documented no acute fracture, malalignment or aggressive osseous lesion.

Review of the (MAR) revealed the resident rated her pain at 0 every day during the month of May of 2024 except 1 time prior to her May 28th fall and 2 times following the fall. She received no as needed acetaminophen for pain during the month of May 2024 until 5/29/24, the day after the fall. She received 5 doses in the last three days of the month.

Facility documentation of the resident walking to meals, scheduled three times a day, reflected the resident walked to a meal only 5 times after her fall on 5/28/24, with dates reviewed through 6/19/24.

The Progress Notes documented the following:

On 5/29/24 at 12:14 am post-fall, resident complaining of increased left knee and hip pain.

On 5/29/24 at 1:48 pm the resident continues to complain of left knee discomfort. Left knee without redness. Able to move knee with assist. Was able to stand on it in therapy, refused to take a step. Refused to get up for lunch, stated I am comfortable and don't want to move to hurt again.

On 5/30/24 at 1:56 pm resident up for a bath this am. Transferred with assist of 2 and the gait belt. Resident was favoring left leg upon transfer complaining of left knee hurting. As needed acetaminophen given and effective. X-rays completed as ordered.

On 6/1/24 at 1:43 pm resident refused to get up for breakfast and ate in her bed. She did get up for lunch and transferred with assist of 2 and was bent over a lot. Left knee slightly swollen, complaining of pain, more if she straightens knee.

On 6/1/24 at 10:21 pm the resident still cannot lay on the left leg. Complains of pain. Treatment done as per order.

On 6/4/24 at 2:59 pm the resident continues with pain discomfort. Rated knee pain at 4/10, as needed acetaminophen given.

On 6/5/24 at 12:59 am resident complained of left knee pain with movement, area slightly swollen. Leg elevated with pillow, diclofenac applied (topical pain reliever) and as needed acetaminophen given.

On 6/5/24 at 1:02 pm resident complaint of left knee pain. Has taken as needed acetaminophen twice and eased pain. She will have leg straight in bed in AM and when this nurse goes in her leg is straight and the she will bend up and complain of pain. Transfer with assist of 2.

On 6/5/24 at 2:24 pm resident refused two times to do restorative exercises complaining her knees are hurting her too much.

(continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/6/24 at 1:17 am resident continues to complain of knee pain, Diclofenac applied. Resident states cream effective, area slightly swollen, and no redness noted. On 6/6/24 at 12:26 pm blood pressure was elevated this am, has subsided and stabilized. Resident having pain in left leg, 7/10. Resident came out for breakfast, but refused for lunch. Sitting on side of bed to eat due to pain. As needed pain medication administered. On 6/7/23 at 12:33 pm received order for resident to have Physical Therapy evaluation due to knee pain. On 6/7/24 at 2:07 pm resident has not asked for acetaminophen at all today, although when biofreeze was applied, resident grabbed and guarded her leg. On 6/8/24 at 6:51 pm resident complained of left hip pain, acetaminophen administered which was ineffective. Aspercream and diclofenac applied with better results. Physician notified and ordered a 2 view x-ray on the left hip for pain and limited range of motion. On 6/9/24 at 2:21 pm resident alert and oriented. Refusing 2 view left hip x-ray that was ordered for pain and limited range of motion. She said she is feeling better now. Review of the Treatment Administration Record revealed a new order was received on 6/1/24 for topical pain medication to the left knee three times a day. The Incident Report dated 6/9/24 documented the resident had a fall at 7:15 pm when transferring the resident to bed. The Incident Report reflected the staff was not using a gait belt when the fall occurred. The Progress Notes documented the following: On 6/10/24 at 4:05 pm resident continues with pain on her left leg, thigh and knee area. Diclofenac applied to area. No new injuries from witnessed fall. On 6/11/24 at 2:02 am as needed acetaminophen during this shift, resident complaining of knee pain, diclofenac cream applied. On 6/11/24 at 2:02 pm resident is alert and oriented with times of confusion. Has pain in both legs although the left leg is worse. Taking acetaminophen as needed although asking for it about every 4 hours. On 6/11/24 at 11:15 pm resident is alert and oriented. Pain to bilateral knees, the left more severe. Treatment completed per orders. Vital signs within normal limits. As needed acetaminophen available for pain. On 6/12/24 at 2:30 pm resident complaining of pain in both knees. She requested to have as needed acetaminophen before getting out bed and was effective. Treatment to knees done and effective. On 6/13/24 at 1:16 am resident reports moderate pain on left knee, does not want to take acetaminophen at this time, diclofenac used. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/14/24 at 11:15 am received verbal order for anterior (front) posterior (back) view of left pelvis/hip (order for an x-ray). On 6/14/24 at 12:16 pm resident is alert with times of confusion. Needs pain medication before breakfast as she has physical therapy afterwards and her pain hinders any progress. 3/10 in left knee. On 6/14/24 at 5:14 pm X-ray report received. No acute fracture or dislocation. On 6/15/24 at 3:37 pm resident continues to receive as needed acetaminophen for complaints of knee pain and states is helping. Resident currently being assisted for all transfers with 2 staff and gait belt, mobility via wheelchair. On 6/16/24 at 3:25 pm resident continues to take as needed acetaminophen 325 milligrams (mg) before breakfast for complaints of knee pain and has been effective, also using topical pain medication to knees. On 6/17/24 at 12:01 pm resident is alert with times of confusion. Having pain in her left knee that she rates 3/10 today. Medication assists with pain although resident has not asked for any today. On 6/18/24 at 2:43 pm resident transfers with assist of 2 and gait belt. States the cream helps her knees. On 6/18/24 at 10:10 pm resident is alert and oriented. Is an assist of two with gait belt. Treatment completed to knees per order. Resident complained of knee pain when transferring. Has not yet asked for as needed pain medications this shift. Review of the (MAR) revealed the resident rated her pain at 0 11 times out of the first 37 entries during the month of June, 2024. She received as needed acetaminophen 18 times during the first 19 days of the month. On 6/19/24 at 11:25 am, the Administrator stated the facility has a quality assurance meeting daily Monday-Fridays. She stated for any falls or incidents, the charge nurse places an immediate intervention onto the care plan and then it is reviewed during the next quality assurance meeting. The intervention is kept if appropriate or updated if needed. Root cause analysis is done, asked the 5 whys of a fall. On 6/19/24 at 12:07 pm, Staff I, LPN stated the normal procedure for a fall is for one employee to stay with the resident and another to get the nurse, if two people are in the room. If only one person is in the room, that person stays with the residents and calls or flags someone down for help. She stated if an injury is suspected, they make the resident as comfortable as possible but leave him/her on the floor until the physician is notified and it is deemed if the resident needs to be sent to the hospital or not. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/19/24 at 3:57 pm, observed Staff F, CNA and Staff G, CNA performing a two person transfer from the bed to the wheelchair for Resident #21. Staff F assisted the resident into a seated position and Staff G obtained footwear for the resident. Staff F obtained a gait belt and a front wheeled walker and set the wheelchair near the bed while Staff G changed the resident's socks and placed her shoes on her feet. Staff F applied the gait belt around the resident. Both staff stood to one side of the resident, holding the gait belt. Staff provided cues for the resident to stand. Once the resident stood, verbal cues were given for taking steps. Staff F moved the wheelchair closer to the resident and verbal cues continued to guide the resident safely into a seated position in the wheelchair. On 6/20/24 at 9:06 am, Resident #21 had her call light on. Staff K, CNA answered the call light and the resident requested to use the restroom. Staff K replied she would go find a second staff member and be right back. On 6/20/24 at 9:07 am, Staff K, CNA and the Assistant Director of Nursing (ADON) were observed transferring the resident from the wheelchair to the toilet. Both employees washed hands and donned gloves. Staff K placed a gait belt on the resident. The ADON guided the wheelchair into the restroom. Staff K assisted the resident to stand at the grab bars and while holding the gait belt, assisted the resident to slowly move to her right towards the toilet. The resident was able to slowly side step to the toilet. The ADON assisted in lowering the residents clothing and Staff K assisted the resident to sit on the toilet. Once safely sitting on the toilet, the call light was given to the resident and staff provided privacy. On 6/20/24 at 9:09 am, Staff K stated the resident had been a two person assist because of pain since her fall, but prior to the fall had been a 1 person assist. The facility policy Falls and Fall Risk, Managing, revision date March, 2018 documented a Policy Statement of Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The portion of the policy titled Resident-Centered Approaches to Managing Falls and Fall Risk Point 1: The staff, with the input of the attending physician, if appropriate, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The portion of the policy titled Monitoring Subsequent Falls and Fall Risk Point 1: The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47079 Based on observations, clinical record review, staff interviews, and policy review the facility failed to ensure a medication error rate of less than 5%. During observations of medication administration, the facility had 2 errors out of 25 opportunities for errors resulting in an error rate of 8% (Residents #23). The facility identified a census of 55 residents. Findings include: On 6/18/24 beginning at 8:13 AM, the administration of 8 pills observed for Resident #23. Two (2) medication errors observed during this time. During the medication pass for Resident #23, observed Staff I, Licensed Practical Nurse (LPN), remove the following medications from the medication cart: (1) Hydrocodone/APAP 7.5/325 mg tablet (1) Aspirin 81 mg tablet (1) Fexofenadine Hydrochloride 180 mg tablet (1) Gabapentin 100 mg tablet (1) Levothyroxine 88 mcg tablet (1) Pantoprazole 20 mg tablet (2) Senna-Plus 50/8.6 mg tablets Staff I, LPN counted the medications, verified there were 8 pills and gave them to the resident. The Clinical Physician Orders revealed an order dated 8/20/22 for the resident to have Fiber 500 mg one (1) tablet for the daily dose. The Clinical Physician Orders did not include an order for Fexofenadine Hydrochloride. On 6/18/24 at 11:51 AM, Staff I verified she gave the resident Fexofenadine Hydrochloride (antihistamine) instead of a Fiber medication because she didn't look at the medication bottle. She also stated the Fiber 500 mg medication was not stocked in the medication cart and was not administered during morning medication administration. A policy titled Administering Medications revised April 2019 indicated medications shall be administered in a safe and timely manner and as prescribed. It also indicated 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. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 2:48 PM, the Director of Nursing (DON) stated three (3) checks should be done when medications are administered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46873 Based on observation, interview, guidance from the 2022 US Food & Drug Administration (FDA) Food Code, and facility policy, the facility failed to serve food in a sanitary manner during breakfast meal service. The facility identified a census of 55 residents. Findings include: Continuous observation of the breakfast meal service began on 6/18/24 at 7:37 am. Staff A, Cook, began preparing breakfast trays and placing them in the serving window to nursing staff to serve to residents. The items served included biscuits, sausage gravy, scrambled eggs, fried eggs, oatmeal, cream of wheat, and fortified hot cereal as well as a variety of cold cereals. Upon the beginning of the observation, Staff A, [NAME] noted to be wearing disposable, single use gloves. She was using tongs to put the biscuits on plates, adding the remainder of the food to the plates, placing the plate on a tray, reaching for a plate cover, and then placing the tray on the serving window. After making several plates, at 7:42 am, Staff A observed to place the tongs to the side of the steam table. For the next 10 plates she prepared, she read the menu card to the tray on her left, picked up a biscuit with her gloved hands, sliced it open with a knife, placed it on a plate, picked the plate up to spoon the gravy over the biscuits, then touched multiple serving utensils, steam tray covers and bowls to add the additional food items per the menu. Using both hands, she set the plate down on the tray, reached down to pick up a food cover, covered the plate, and picked up the tray with both hands to place in the serving window. Her gloved hands were touching the ready to eat food, the plates, the trays, the plate covers and the serving utensils on steam table and for the cold cereals for multiple trays prepared. At 8:00 am, the Certified Dietary Manager (CDM) noted Staff A touching the food instead of using tongs. When asked if she needed tongs Staff A responded she had tongs there but didn't need them. Staff A stated she had been wearing gloves when she set up the steam table so felt everything she was touching was considered clean so it was ok to touch the food. The CDM provided education to Staff A and the meal service completed with Staff A using tongs for the ready to eat food. The CDM stated Staff A is new to her role and will continue to receive education on food service. Chapter 3 - 14 of the FDA Food Code 2022 directs: If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. The facility policy Preventing Foodborne Illness - Food Handling, revision date July, 2014 reflected a Policy Statement of: Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47079 Based on observation, staff interviews, and policy review, the facility failed to protect resident information from unauthorized access for 5 of 5 residents (#33, #54, #59, #219, #268). The facility reported a census of 55 residents. Findings include: On 6/17/24 at 6:48 AM, observed a document titled Hall 2 Hot Chart dated 6/17/24 on a medication cart that included visible personal health information for 5 residents. On 6/17/24 at 8:24 AM, Staff H, Licensed Practical Nurse (LPN) stated the sheet on the medication cart was a communication sheet that contained resident information. A policy titled Confidentiality of Information and Personal Privacy revised October 2017 indicated the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. It also indicated access to resident personal and medical records will be limited to authorized staff and business associates. On 6/19/24 at 2:48 PM, the Director of Nursing (DON) stated communication sheets should not be facing up with resident information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, staff interviews, record reviews, and policy review, the facility failed to identify areas or devices in the building to reduce the risk and prevent the growth of Legionella or other waterborne pathogens. The facility also failed to appropriately perform hand hygiene and failed to protect stock treatment supplies from cross-contamination. The facility reported a census of 55 residents. Findings include: 1. On 6/19/24 at 12:58 PM, Staff B, Maintenance Supervisor, stated the facility had three showers used to bathe residents. He stated one shower was routinely used and the other two were used secondary if the primary shower was out of service. At 12:58 PM, Staff B, Maintenance Supervisor, stated the secondary showers' water supply lines had been routinely flushed but hadn't been documented. An undated document titled Weekly Flushing of Plumbing Fixtures for un-used rooms directed staff to run water in all sinks, faucets, showers, and tubs for at least three minutes and to flush all toilets three times to completely empty tanks and traps. Staff B revealed the form had not been completed. A policy titled Legionella Water Management Policy revised 2017 indicated the purposes of the Water Management Program were to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. On 6/19/24 at 2:52 PM, the Administrator stated there were four (4) resident showers and one (1) was not routinely used. She also stated staff should follow the aforementioned facility policy. 50471 2. The Minimum Data Sheet (MDS) assessment dated [DATE] for Resident # 27 identified Moisture Associated Skin Damage (MASD). The MDS documented diagnoses that included: septicemia, diabetes mellitus (DM), and infection and inflammation reaction due to internal right knee prosthesis. The MDS revealed the resident received pressure reducing device for the bed and pressure reducing device for the chair. The Care Plan of Resident #27, revision date 5/27/24 reflected a focus area of skin impairment. The Care Plan documented the resident to have excoriation of the coccyx. (the tailbone). The Order Entry documented Resident #27 to have an order for a 1:1 ration of [NAME] (Calmoseptine, a moisture barrier ointment) and antifungal to be applied to the buttocks twice a day until healed. (continued on next page)

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 06/20/2024
NAME OF PROVIDER OR SUPPLIER Creston Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Cottonwood Drive Creston, IA 50801	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/24 at 9:46 AM, observed Staff J, Licensed Practical Nurse (LPN) performing a treatment to Resident #27's buttocks. Staff J obtained two tubes of the prescribed ointments from the medication cart and brought them into the resident's room. Staff J verified the ointments were stock supply and were not dedicated for single patient use. Upon entering the room, Staff J was not observed to have performed hand-washing or hand hygiene prior to donning gloves. After donning gloves, Staff J provided incontinent care on Resident #27. Without changing gloves or performing hand hygiene, Staff J then squeezed a proper amount of ointment from the first treatment tube into her hand. She then picked up the second tube of treatment cream and placed that ointment into her hand as well to combine the two ointments. She then applied ointments to Resident #27's buttocks, failing to change gloves or perform hand hygiene. Staff J then removed the soiled gloves, but did not perform hand-washing or hand hygiene. Staff J performed hand-washing prior to exiting the room. Staff J took the ointment containers out of the room and placed them back in the medication cart. Staff J failed to prevent cross contamination, exposed the ointment containers during treatment. In an interview on 6/19/24 at 2:17 PM, the Director of Nursing (DON) reported staff should be placing the ointment in a medication cup, hand-washing or hand hygiene should be completed prior to the treatment, when visibly soiled, and after disposing soiled gloves. The facility policy title Handwashing/Hand Hygiene revised 8/2019 included the following documentation: Policy Statement-This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a. When hands are visibly soiled 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents c. Before preparing or handling medications d. After contact with a resident's intact skin e. After removing gloves f. After personal use of the toilet or conducting your personal hygiene. 8. Hand Hygiene is the final step after removing and disposing of personal protective equipment. 49628 (continued on next page)

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 06/20/2024
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The Progress Note in the Electronic Medical Record (EHR) dated 5/31/24 completed by the Director of Nursing (DON) revealed Resident #54 scored 14/15 on the Brief Interview for Mental Status (BIMS) score indicating the resident is cognitively intact. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 presented upon admission to the facility with an indwelling catheter. Resident #54 presented with medical a diagnosis of obstructive and reflux uropathy, unspecified. Orders dated 5/27/24 revealed use of enhanced barrier precautions due to indwelling Foley catheter. The Care Plan printed 6/19/24 included the following interventions: catheter care every shift, monitor and document any pain or discomfort related to the catheter, monitor, document and report as needed any signs or symptoms of urinary tract infection, and enhanced barrier precautions when performing high-contact care activities. Observation on 6/19/24 at 2:10 PM Staff C, Certified Nursing Assistant, donned gown and gloves prior to entering Resident #54's room for management of catheter bag. Staff C obtained supplies including a clean trash bag, gradient cylinder, and alcohol wipe from the resident's bathroom. Staff C provided education to the resident regarding the need to empty the catheter. The staff placed the trash bag on the floor, and the cylinder on top of the trash bag. The staff wiped the drainage tube with the alcohol wipe and proceeded to drain the bag. Staff C emptied the cylinder into the toilet with the trash bag remaining under the cylinder during emptying and rinsing. Staff removed a single glove while in the resident's room, and removed the gown and remaining glove while exiting the room. Staff C discarded the gloves and gown in a labeled trash receptacle in the hallway. The staff opened 3 drawers of a storage container outside the resident's room before locating the hand sanitizer. On 6/19/24 at 2:24 Staff C stated it would have been helpful if hand sanitizer would have been out to use prior to putting gloves on. In an interview on 6/19/24 at 2:17 PM the DON stated staff should complete hand hygiene at the start of treatment, when gloves are visibly soiled, when removing dirty gloves and when leaving a resident's room. The facility policy titled Handwashing/Hand Hygiene revised August 2019 instructed staff to perform hand hygiene prior to applying non-sterile gloves.