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	07/01/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interviews, and policy review the facility failed to properly secure and store medications to minimize loss or access for 1 of 3 medication carts. The facility reported a census of 47 residents. Findings include:Continuous observation on 6/28/26 at 3:37 PM an unlocked treatment cart at the nurses' station with no staff present. Observed 6 residents in the area seated in wheelchairs or dining chairs in the living/dining area. The medication cart contained the following:The top right drawer contained stock medications including aspirin 81, Bisacodyl, magnesium, acetaminophen.The second right drawer down contained prescribed medications for 12 residents.The third right drawer down contained prescribed medications for 9 residents.The bottom right drawer contained liquid laxative, inhalers, nebulizer solution, antacids, and cough syrup.The top left drawer contained scissors and a pill cutter.The second left drawer down was locked.The third left drawer down contained lancets.At 3:43 PM the Administrator walked up to the open medication cart and asked where the nurse was. Staff F, Licensed Practical Nurse (LPN), walked up the nurses station, and over to the unlocked medication cart. Staff F confirmed the medication cart was unlocked by opening a drawer, stated that this was not her medication cart, but would lock it. Staff F proceeded to lock and secure the medication cart. On 6/28/26 at 4:01 PM Staff G, LPN, walked up to the locked medication cart and acknowledged she was the nurse who was assigned to that cart since 6:00 AM. The staff stated she should have locked the medication cart before she walked away.On 6/30/26 at 11:31 AM the Interim Director of Nursing (DON) stated the staff know the medication cart(s) need to be locked when they are not using them. The Interim DON stated she had personally provided education to all staff who provide medications and expectation that the medication carts be locked.On 6/30/26 at 12:45 PM the Regional Director of Clinical Services expected the medication carts would be locked when not in use. The facility's Security of Medication Cart Policy, undated, revealed the medication carts must be securely locked at all times when out of the nurse's view. The document included when the medication cart is not being used, must be locked and parked at the nurses' station.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, menu review, clinical record review, staff interviews, and policy review, the facility failed to serve all of the menu items to seven (7) residents who were ordered pureed diets. The facility reported a census of 47 residents.Findings include:On 6/30/26 at 11:19 AM, a meal service observation revealed Staff I, cook, reviewed the diet sheet in the kitchen, verified the menu items to be served, and stated there were seven (7) residents who were prescribed pureed diets. She pureed eight (8) servings of broccoli and chicken but did not puree wheat rolls.During a continuous lunch service observation that began on 6/30/26 at 11:19 AM and ended at 12:22 PM, all seven (7) pureed diets were served without pureed wheat rolls.On 6/30/26 at 12:40 PM, a menu review approved 3/11/26 revealed one (1) wheat roll was included in each pureed diet.On 6/30/26 at 1:00 PM, Staff I stated she forgot to include the dinner roll in the pureed diets during preparation and service. The Certified Dietary Manager (CDM) asked Staff I if the roll had been added to the other pureed items to which Staff I replied no.On 7/01/26 at 7:41 AM, the Administrator stated the menu should be followed. Food that is on the menu should be served.A policy titled Therapeutic Diets revised [DATE] indicated therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and policy review the facility failed to provide food at an appetizing temperature to 4 of 8 residents reviewed (Resident #5, #8, #14 and #23) The facility reported a census of 47 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #5 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment.On 6/28/26 at 3:54 PM Resident #5 stated occasionally the warm food can be served cold and he would like it warm. Resident #5 stated he does not ask for staff to warm the food up but thought they would. 2. The MDS dated [DATE] revealed Resident #8 had a BIMS of 15 indicating no cognitive impairment. On 6/28/26 at 3:19 PM Resident #8 stated the food just did not have any taste to it at all. Resident #8 stated the food is served cool once in a while as well.3. The MDS dated [DATE] revealed Resident #14 had a BIMS of 13 indicating no cognitive impairment. On 6/28/26 at 1:29 PM Resident #14 stated she mostly eats soup at dinner time and the soup was not served as warm as she would like. Resident #14 stated the lunch is not always as hot as she would like. Resident #14 stated she never asked the staff to warm the food up but she thought they would. 4. The MDS dated [DATE] revealed Resident #23 had a BIMS of 15 indicating no cognitive impairment. On 6/28/26 at 3:29 PM Resident #23 stated the food was frequently served cooler than she would like. Resident #23 stated the food was cold sometimes. Resident #23 stated she does not ask them to heat the food up but thought they would heat the food up if needed. Observation on 7:35 AM of hall 5 breakfast tray delivery revealed at 7:36 AM Resident #39's breakfast tray was taken back to the end of the hall dining room. At 7:45 AM Resident #39 was assisted in his wheelchair to the table. At 7:47 AM breakfast tray given to Resident #39. At 7:47 AM the sample tray was taken to the kitchen. At 7:47 AM the breakfast tray arrived at the kitchen for a temperature check. Cream of wheat temperature was 118 degrees and scrambled eggs were 115 degrees.On 7/01/26 at 7:57 AM Staff N, Certified Dietary Manager (CDM) stated she worked at the facility for about 9 years. Staff N stated the temperatures of the food delivered to Resident #39 should have been higher when the resident received the meal. Staff N stated she would like to see the food delivered to the resident at or above 135 degrees. On 7/1/26 at 10:10 AM the Administrator stated the policy documented the food temperature of food delivered to the resident should be 135 degrees or above.Review of policy revised 12/13 provided by the facility titled, Assisting the Resident with In-Room Meals documented to check to ensure the hot foods are hot and the cold foods are cold. Be sure the resident is ready to receive the meal. To minimize the risk of foodborne illness, the time that potentially hazardous food remains in the danger zone (41 to 135) would be kept to a minimum.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and policy review, the facility failed to date and label previously opened food packages or properly store food in the freezer and dry goods storage room. The facility reported a census of 47 residents. Findings include:On 6/28/2026 at 9:50 AM, an initial kitchen tour revealed the following items:Four (4) serving trays with multiple uncovered, unlabeled, and undated small plates containing square items and multiple small bowls of pudding-like substance were stored in the refrigerator.An unlabeled bag of small, irregularly oval shaped items was stored in a bin labeled cereal but did not identify the type.An undated, previously accessed bag of mild cheddar cheese was stored in the walk-in refrigerator.Two (2) unlabeled, resealable bags of green leafy items dated 6/23 were stored in the walk-in refrigerator.On 6/28/26 at 10:12 AM, Staff H, cook, told the Certified Dietary Manager (CDM) the 4 trays were not labeled at the beginning of the survey tour. The CDM replied that they should have been.On 7/01/26 at 7:41 AM, the Administrator stated stored food should be labeled.A policy titled Food Receiving and Storage revised [DATE] indicated opened containers must be dated and sealed or covered during storage.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews, and policy review, the facility failed to follow the physician's orders for one (1) resident (#56) by failing to apply a leg immobilizer while the resident was in bed. The facility reported a census of 47 residents. Findings include:Resident #56's Minimum Data Set (MDS) for Resident #1 dated 6/25/26 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of traumatic brain injury (TBI), a stroke, one-sided weakness, and a right arm fracture. It indicated the resident was admitted on [DATE] and his functional abilities had not yet been assessed.A Physician's Order dated 6/22/26 indicated the resident had a right leg fracture and included an order for right leg immobilizer to remain in place when resident is in bed and overnight. Ok to remove when up ambulating and working with <physical therapy> PT.A Nurses Note Progress Note dated 6/22/26 at 2:17 PM indicated the resident had surgery on his right hip and was to wear the right lower extremity immobilizer when at rest.The Care Plan dated 6/22/26 directed staff that right leg immobilizer to remain in place when resident is in bed and overnight. Ok to remove when up ambulating and working with PT.On 6/28/26 at 3:15 PM, Resident #56 was observed asleep in his bed. His immobilizer was not applied to his right leg and was observed lying on the top of his dresser.On 6/28/26 at 3:32 PM, Staff K, Certified Medication Aide (CMA) responded to Resident #56's call light. The immobilizer was not on his right leg after she exited the room.On 6/29/26 at 2:18 PM, Resident #56 was observed asleep in his bed. His immobilizer was not on his right leg and was observed lying on his dresser.On 6/29/2026 at 2:20 PM, Staff K stated CMAs and <Certified Nurse Aides> CNAs can apply or remove assistive devices such as arm slings and leg immobilizers because they received specialized training from <physical> therapy.On 6/29/26 at 2:21 PM, Staff L, CNA stated he doesn't have it on when he's working with PT. She also stated she asked the CMA if it could be left off because he didn't have it on that morning when she went to get him up. She stated the CMA said it was ok to leave off.On 6/29/26 at 2:30 PM, Staff K stated the resident does not like the leg brace and doesn't understand its intention. She also stated he verbally said no today but did not notify the nurse of his refusal. She further stated there was no reason she didn't apply it on 6/28/26 but added there was no place to document the resident's refusal to wear it.The June 2026 Medication Administration Record (MAR), Treatment Administration Record (TAR), and Supplemental Documentation did not include the resident's leg immobilizer for staff to monitor.On 6/29/26 at 2:47 PM, Staff M, Licensed Practical Nurse (LPN) stated she was not notified that his leg brace was not applied. She also stated the order to keep his immobilizer on his RLE while asleep in bed or working with PT did not transition to the area where staff can document refusals. She added it to the MAR for staff to document if the resident refuses.On 6/29/26 at 2:58 PM, Staff M telephoned Staff K and asked if she notified the physician when she was in the building that morning. Staff K was heard stating she did not notify the provider that the resident refused the immobilizer.On 7/01/26 at 7:37 AM, the Director of Nursing (DON) stated the mobilizer needed to be on while he is at rest.The facility did not have a policy specific to following physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for 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 observation, clinical record review, staff interview, and policy review, the facility failed to lock the wheelchair during a transfer for 1 of 5 residents dependent on mechanical lift transfers (#40). The facility reported a census of 47 residents.Findings include:Resident #40's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of anxiety, depression, schizophrenia, muscle weakness, and unsteadiness on feet. It indicated she required setup assistance with eating, moderate assistance with oral hygiene, and was dependent with all other Activities of Daily Living (ADLs) and mobility. It also indicated she used a wheelchair for mobility.The Care Plan initiated 10/16/23 indicated the resident was dependent with transfers and directed staff to use a 2-person, mechanical lift with a sling for transfers.On 6/28/26 at 12:46 PM, Staff G, Licensed Practical Nurse (LPN) and Staff J, Certified Medication Aide (CMA) transferred Resident #40 in a mechanical lift from her wheelchair to her bed. The wheelchair was observed unlocked when she was lifted from the wheelchair.On 6/28/26 at 1:13 PM, Staff J stated wheelchairs should be locked when using a mechanical lift to transfer residents. She also stated they noticed the wheelchair was unlocked after they transferred Resident #40 to her bed.On 6/28/26 at 3:52 PM, Staff G stated they forgot to lock the resident's wheelchair but added it should have been locked during the transfer.On 7/01/26 at 7:37 AM, the Director of Nursing (DON) stated wheelchairs should be locked during resident transfers.A policy titled Lift - Mechanical revised 4/08/15 directed the user to position the wheelchair and lock the wheels when transferring a resident.