STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165287	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Specialty Care	451 West Orange Street West Branch, IA 52358

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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 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. Based on observations, clinical record review, resident and staff interviews, and facility policy review, the facility failed to provide a respectful, dignified environment and care to 3 out of 10 residents reviewed (Residents #14, #16, and #44). The facility reported a census of 58 residents. Findings Include:1. The Minimum Data Set (MDS) Assessment for Resident #16 dated 9/26/25, revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicated intact cognition. The MDS indicated Resident #16 dependent on staff for toileting, personal hygiene and meeting physical needs related to immobility. The Care Plan for Resident #16 dated 7/5/24, and revised on 7/15/25, identified resident required moderate assist, from two persons for toileting, EZ Stand lifts (brand name of a type of lift that assists a person from a sitting position to a standing position and then staff are able to push the resident in a safe manner to the desired location), upper and lower body dressing and resident is dependent on staff to assist and escort to activities. During an observation on 11/12/25 at 5:15 PM, Staff F, Certified Nurse Aide (CNA), delivered a meal to Resident #16. As the staff member entered the room the resident asked her if it was the correct meal. The staff member lifted the tray cover and said, No, it is fish, I will go get you the alternative. The resident advised that they are aware, she doesn't eat fish and she is never asked what she would like and the staff most often bring her back a hotdog. The resident was not asked what she wanted and not given any options for alternatives. The resident shared that they fix the meal and you either like it or you don't. The alternative is whatever they bring you. The resident was served a loose meat sandwich, which was not on the menu or the alternative menu. During an interview on 11/12/25 at 5:25 PM, Staff F, CNA, queried about the meal served to Resident #16 and she stated the meal trays aren't always correct but she should have asked the resident what she wanted instead of just bringing something back. She stated that she did not know what items were on the alternative menu. Staff F expressed concern that there is not enough staff and sometimes they are not able to get everything done. 2. During an interview on 11/12/25 at 1:40 PM, Resident #44 stated he has bowel incontinence and has frequent diarrhea. He stated he does not have the ability to control his bowels and it is unpleasant and embarrassing. Resident #44 sat in his wheelchair, and wore a t-shirt and sweat pants. An odor of feces and urine noted in his room, with what appeared to be dried feces on the resident's sheets and the floor. When queried, the resident indicated the sheets were soiled last night (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165287	A. Building B. Wing	12/03/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #44, dated 10/11/23 revealed a Focus area to address I have diarrhea and bowel incontinence. Interventions included: I request to have barriers placed in the bathroom covering the walls d/t (due to) my bowel incontinence. The Care Plan, dated 10/11/23 included a Focus area address Activities of Daily Living (ADL's). Interventions included, in part: Toileting – Ax (assist) x 1 – commode over toilet seat; Upper Body Dressing – Ax 1; Lower Body Dressing – Ax 1. During an observation on 11/13/25 at 11:15 AM, in Resident #44's bathroom what appeared to be dried feces noted on the surface around the toilet. During an observation on 11/17/25 at 8:55 AM, in Resident #44's room what appeared to be dried feces noted on the floor between the bed and the bathroom, and the bed sheets were visibly soiled with a brown substance. During an observation on 11/18/25 at 12:25 PM, in Resident #44's room the sheets on the bed noted to be soiled, and what appeared to be dried feces noted on the bathroom floor. On 11/19/25 at 7:55 AM, the Dietary Manager was queried. She advised she had entered Resident #44's room in the past and has seen his sheets soiled. Document titled, Job Description: Certified Nursing Assistant identified the following as a responsibility of a Certified Nursing Assistant: Performs incidental housekeeping and maintenance tasks as may arise during the course of regular duties, in order to maintain a clean, safe, pleasant environment for residents, visitors, and staff. 3. Review of Resident #14's MDS assessment, dated 11/2/25, revealed that Resident #14 had a BIMS score of 6 out of 15, which indicated severe cognitive impairment. The list of diagnoses included Alzheimer's disease, left femur fracture, and malnutrition. The MDS indicated Resident #14 was always incontinent of bowel and dependent on staff assistance for all transfers, bed mobility, dressing, and toilet hygiene cares. Review of the Care Plan, date initiated 10/28/25, revealed a Focus area to address activities of daily living (ADLs). Interventions included, in part: I am dependent on two staff for assistance with bed mobility. I am dependent on two staff for assistance with upper and lower body dressing. During an observation on 11/25/25 at 3:18 PM, Resident #14 found to be laying supine (on back) in bed, perineal area was without an incontinent product in place, and pants were left pulled down around the resident's ankles. During an observation on 11/15/25 at 3:50 PM, the Director of Nursing entered Resident #14's room, Resident #14 remained lying supine in bed without incontinent product to cover perineal area, and pants continued to be left down around the resident's ankles. Resident #14 stated she was cold, the DON assisted resident with incontinence cares and dressing. During an interview on 11/25/25 at 3:45 PM, the DON stated that residents should not be left with pants down around ankles in bed, unless the resident had requested this. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Facility Resident Rights, Policy Statement, revised December 2016. Policy Interpretation and Implementation section included, in part: Federal and state laws guarantee basic rights to all residents of this facility. These rights include the resident's right to, in part: a. A dignified existence; b. Be treated with respect, kindness and dignity;

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review, staff interviews and facility policy review the facility failed to obtain consent for an antipsychotic medication for one out of five residents reviewed for unnecessary medications (Resident#6). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #6 dated 6/13/25, listed diagnoses of Non-Alzheimer's dementia, and depression. The MDS reflected a Brief Interview for Mental Status (BIMS) score of 9 out of 15, moderate cognitive impairment. The High-Risk Drug Classes: Use and Indication section lacked an antipsychotic medication used in the 7 day look back period. The MDS assessment for Residnet#6 dated 9/12/25, listed diagnoses of Non-Alzheimer's dementia, and depression. The MDS reflected a BIMS score of 11 out of 15, moderate cognitive impairment. The High-Risk Drug Classes: Use and Indication section reflected an antipsychotic medication with indication used in the 7 day look back period. The MDS revealed antipsychotics were received on a routine basis. The Care Plan for Resident #6 date 12/11/2025, failed to include the use of an antipsychotic medication. The Progress Note dated 7/15/2025 at 5:28 PM reflected Resident #6 saw the provider who ordered risperidone 0.25 milligrams (mg) two times a day. The Progress Note dated 7/15/2025 at 9:14 PM identified risperidone tablet 0.25 mg give 1 tablet by mouth two times a day related to dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The Progress Note for Resident #6 dated 6/15/25 through 7/15/25 failed to include consent from the resident's responsible party.Review of the facility Evaluations revealed a lack of an Informed Consent for Psychotropic Medication dated July, 2025 for risperidone. On 12/03/2025 at 9:18 AM, the Registered Nurse (RN) | Regional Director of Clinical Services reported the consents are in the evaluation. On 12/03/2025 at 11:01 AM, the Administrator reported the facility failed to obtain consent for Resident#6 risperidone when it started in July to 12/3/25. On 12/03/2025 at 12:19 PM, Staff A, Licensed Practical Nurse (LPN) reported the nurse who got the order for a psychotropic medication needed to call the family or the resident and obtain the consent for use. She stated the consent is documented in the chart. The facility provided a policy titled Antipsychotic Medication Use dated 12/2016, identified informed consent will be obtained.

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	165287	A. Building B. Wing	12/03/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to maintain a clean environment and resident equipment. The facility reported a census of 58 residents.Findings include:1. During an observation on 11/18/25 at 10:50 AM, a full body mechanical lift located in the 100 hallway had a brown colored smear on the left side of lift leg. On Nov. 19, 2025 at 12:32 PM, the brown smear remained on the mechanical lift leg. During an observation on 11/18/25 at 11:06 AM, a mechanical sit to stand lift on the 200 hallway, had the foot plate heavily soiled with various debris. On Nov. 19, 2025 at 12:35 PM, the debris remained on the foot plate of the sit to stand lift. During an observation on 11/18/25 at 8:50 AM, a high back wheelchair kept in the hallway, outside of room [ROOM NUMBER], had a yellow stained towel kept on the wheelchair seat. At 12:19 PM, the wheelchair remained in the hallway, outside of room [ROOM NUMBER] and the yellow stained towel rested on the seat. During an observation on 11/19/25 at 12:39 PM, the bathroom in resident room [ROOM NUMBER] had brown spots and smears on the floor near the toilet, and a soiled incontinence pad rested on the bed. During an interview on 11/20/25 at 11:00 AM, Staff S, Certified Nursing Assistant (CNA), reported that all staff were responsible for cleaning the mechanical lifts and that CNAs were primarily responsible for changing bed linens, changing incontinence pads, and making the resident's beds. Staff S stated that soiled incontinence pads should not be left on the bed due to infection control. During an interview on 11/24/25 at 9:35 AM, Staff L, CNA, reported that CNAs were responsible for cleaning the mechanical lifts, changing bed linens, changing incontinence pads, and making resident's beds. Staff L stated that soiled incontinence pads should be changed immediately for the health and safety of residents. Review of the facility policy titled, Cleaning and Disinfection of Environmental, revised August 2019 revealed a Policy Statement which declared Environmental surfaces will be cleaned and disinfected according to current CDC (Center for Disease Control) recommendations for disinfection of healthcare facilities and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. The Policy Interpretation and Implementation section directed, in part: a. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibility soiled. b. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.

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	165287	A. Building B. Wing	12/03/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and facility policy review, the facility failed to provide twice weekly bathing for 4 of 5 resident (R#6, R#29, R#43, and R#60) and failed to provide assistance with incontinence cares for 1 of 5 residents (Resident #15) reviewed for activities of daily living (ADLs). The facility reported a census of 58 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment, dated 10/3/25, revealed that Resident #15 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated a severe cognitive impairment. The list of diagnoses included Non-Alzheimer's dementia, schizophrenia, and congestive heart failure. The MDS identified Resident #15 incontinent of bladder, and occasionally incontinent of bowels. Review of Resident #15's Care Plan, initiated on 1/19/24, revealed a Focus area to address activities of daily living (ADL's). Interventions included, in part: a. Mobility - independent with wheelchair. Date initiated: 1/19/24. b. Toileting – Ax 1 (assist of 1). Date initiated: 1/19/24. c. Transfer – Ax 1 with walker. Date initiated: 1/19/24. d. Lower Body Dressing – Ax 1. Date initiated: 1/19/24. During an observation on 11/18/25 at 11:02 AM, Resident #15 self-propelled wheelchair down 200 hallway, away from his room, towards the dining room. The front of the residents' pants and shirt near his waist visibility wet. Staff L, Certified Nursing Assistant (CNA) reported that Resident #15 was very independent and would not let staff change him, Staff L stated she would try to reapproach him, then walked away from Resident #15. At 11:07 AM, Staff L set clothing on Resident #15's bed and then notified Resident #15 that there was clothing on his bed to change into. At 11:12 AM, Resident #15 entered his room and shut the door, no staff entered room to assist Resident #15 with dressing or incontinence cares. During an interview on Dec. 03, 2025 at 4:30 PM, the Director of Nursing (DON) reported that Resident #15 often had an altered reality and could be non-compliant with cares. The DON informed that staff should reapproach Resident #15 and try to talk with him about completing incontinent cares. The DON identified that Resident #15 required the assistance of one staff member for transfers and toileting hygiene. The DON stated that Resident #15 would not be able to clean himself up if he had been incontinent. 2. Review of the MDS assessment, dated 11/17/25, revealed that Resident #29 had a BIMS score of 14 out of 15, which indicated intact cognition. The MDS indicated Resident #29 did not exhibit rejection of care behavior. and had not exhibited rejection of care behavior. The MDS identified that Resident #29 required substantial to maximal staff assistance with bathing/showering. Review of the census report revealed that Resident #29 admitted to the facility on [DATE] and discharged from the facility on 11/19/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's Care Plan, initiated on 11/11/25, revealed a Focus area to address activities of daily living. Interventions included, in part Bathing – 1 am A x 1. Review of the facility bathing record, dated between 11/01/25 and 11/30/25, revealed that Resident #29 had no documented baths during her 11/11/25 to 11/19/25 stay at the facility. baths documented while residing in the facility. No incidents of refusals to bath documented in the record. 3. Review of the MDS assessment, dated 11/17/25, revealed that Resident #43 had a BIMS score of 6 out of 15, which indicated severe cognitive impairment. The MDS indicated Resident #43 had not exhibited rejection of care behavior. The MDS identified that Resident #43 required substantial to maximal staff assistance with bathing/showering. Review of Resident #43's Care Plan, initiated on July 18, 2925, revealed a Focus area to address activities of daily living. Interventions included, in part: Bathing – I am moderate Ax 1. Review of the facility bathing record, dated between 11/06/25 and 12/01/25, revealed the following documentation of Resident #43's baths/showers: a. On 11/06/25, bath not attempted due to medical condition or safety concerns. b. On 11/10/25, bath not attempted due to medical condition or safety concerns. c. On 11/13/25, Resident #43 refused a bath. d. On 11/20/25, bath was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. e. On 11/24/25, Resident #43 not available for bath. f. On 11/27/25, Resident #43 dependent on staff assistance with the bathing task. The bathing documentation revealed that Resident #43 had no bath for 7 days, between the dates of 11/06/25 and 11/13/25. On 11/13/25 Resident #43 refused to bathe. Resident #43 then went another 14 days, between the dates of 11/13/25 and 11/24/25, without a bath/shower. During an interview on Nov. 24, 2025 at 11:35 AM, Staff L, CNA, stated that Resident #43 never refuses cares and likes to be clean. Staff L reported that it had been a while since she had given Resident #43 a shower. 4. Review of the MDS assessment, dated Oct. 30, 2025, revealed that Resident #60 admitted to the facility on [DATE]. Resident #60 had a BIMS score of 15 out of 15, which indicated intact cognition. The MDS indicated Resident #60 had not exhibited rejection of care behavior. The list of diagnoses included adult failure to thrive, intellectual disability, bipolar disorder, and cellulitis of lower limbs. Review of Resident #60's Care Plan, initiated on Oct. 26, 2025, revealed a Focus area to address activities of daily living. Interventions included, in part: Bathing – I am a substantial assist of 1. (continued on next page)

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	165287	A. Building B. Wing	12/03/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility bathing record, dated between 11/04/25 and 11/19/25, revealed one entry documented on 11/16/25 that Resident #60 had refused a bath/shower. The bathing documentation revealed that Resident #60 had no bath for 12 days, between the dates of 11/04/25 and 11/16/25. On 11/16/25 Resident #60 refused to bathe. Resident #60 then went another 3 days, between the dates of 11/16/25 and 11/19/25, without a bath/shower. Further review of the electronic health record revealed a lack of documentation to indicate Resident #60's received a bath between an admission date of 10/24/25 and 11/19/25, a period of 27 days. During an interview on 11/24/25 at 11:35 AM, Staff L, CNA, stated that Resident #60 would rarely refuse to shower as he liked to be clean. Staff L denied having personally assisted Resident #60 with bathing. Staff L stated that if a resident refused to bathe, staff were expected to reapproach, try again at another time, and let the nurse know about refusal. During an interview on 12/01/25 at 9:00 AM, Staff N, CNA, stated that the 2:00 PM to 10:00 PM shift would have 5 resident baths scheduled and when only one or two CNAs worked, the baths would not always be completed. During an interview on 12/3/25 at 4:30 PM, the DON revealed an expectation that CNA staff document and report to the nurse any resident refusals of bathing, or if staff were unable to complete a scheduled bath. The DON was unable to provide additional bathing record documentation. 5. Review of the MDS assessment for Resident #6, dated 6/13/25, revealed a BIMS score of 9 out of 15, which indicated a moderate cognitive impairment, The MDS indicated Resident #6 frequently incontinent, and required moderate assistance for toileting, bathing and personal hygiene. Review of the Resident #6's Care Plan, dated 7/5/24, revealed a Focus area to address activities of daily living. Interventions included, in part: Bathing – I am Moderate Ax 1, and Personal Hygiene – I am Partial Ax 1. During an observation on 11/24/25 at 2:20 PM, Resident #6 appeared unshaven and with greasy hair. His clothing appeared dirty. During an observation on 11/25/25 at 8:20 AM, Resident #6 sat in the dining room. He appeared unkept and to be wearing the same clothes as observed on 11/24/25. During an interview on 12/3/25 at 2:30 PM, Staff L, CNA queried regarding Resident #6 refusing to shower or take a whirlpool bath. Staff L stated she has never known Resident #6 to refuse to shower or sit in the whirlpool tub as he loves his baths. Staff L stated the facility does not have a bath aid and there are days they are short staffed and showers do not get done. Review of the facility bathing record revealed between 11/13/25 and 12/1/25 Resident #6 a. Received a bath on 11/13/25. b. On 11/17/25 staff documented Not applicable-Not attempted c. On 11/20/25 staff documented resident refused. (continued on next page)

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	165287	A. Building B. Wing	12/03/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 11/27/25 staff documented not attempted due to environmental limitations (e.g., lack of equipment, weather constraints). e. On 12/1/25 staff documented the resident was dependent on staff and did none of the effort to complete the activity. Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, revised on March 2018 revealed a Policy Statement which declared Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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	165287	A. Building B. Wing	12/03/2025

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and facility policy review, the facility failed to assess and follow physician treatment orders for non-pressure wound care for 2 of 3 residents (Resident #29 and Resident #2) reviewed for assessment and intervention. The facility reported a census of 58 residents. Findings include: 1. Review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #29 admitted to the facility on Nov. 11, 2025. Resident #29 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. The list of diagnoses included peripheral vascular disease (a circulation disorder affecting blood vessels outside of the heart, can slow healing), traumatic compartment syndrome (swelling caused by an injury that can cause severe disproportionate pain) of the left lower extremity, diabetes mellitus type 2, and atrial fibrillation. The MDS indicated Resident #29 required substantial to maximal amount of staff assistance with lower body dressing, putting on/taking off footwear, bed mobility, and all transfers. The MDS documented that Resident #29 had no venous or arterial ulcers at the time of the assessment. Review of the Care Plan, initiated on 11/11/25 revealed a Focus area for Resident #29 having impairment to skin- bilateral skin area to heels with the goal that Resident #29 would have no complications related to skin impairment. Interventions included, in part: a. Educate me, my family, and caregivers of causative factors and measures to prevent skin injury. Date initiated 11/11/25. b. Provide Enhanced Barrier Precautions (EBP). Date initiated: 11/11/25. c. Monitor for and document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection to the physician. Date initiated: 11/11/25. d. Weekly treatment documentation to include, measurement of each area of skin breakdown, type of tissue and exudate, and any other notable changes or observations. Date initiated: 11/11/25. Review of an admission evaluation, dated 11/11/25, revealed that Resident #29 had a non-pressure wound, and listed a vascular wound to the right heel and a vascular wound to the left heel. The evaluation lacked documentation of wound measurements or assessments related to appearance and healing. Review of the November 2025 Treatment Administration Record (TAR), revealed an order for bilateral heel wound care, started on 11/13/25, which instructed wounds to be cleansed with saline or soap and water, apply treatment of Medihoney sheet to the base of the wound, cover wounds with a padded dressing and wrap with gauze bandage. The wound care was ordered to be completed one time a day every Monday and Thursday. The TAR identified the following documentation: a. On 11/13/25 – no documentation present to indicate scheduled care completed. b. On 11/17/25 - Staff A, Licensed Practical Nurse (LPN) documented resident refusal c. On 11/20/25 – no documentation present to indicate scheduled care completed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an electronic health record (EHR) encounter note, dated 11/13/25 revealed, in part: Chief Complaint/Nature of Presenting Problem: Skilled admission.She [Resident #29] endorses severe bilateral lower extremity pain making it very difficult for her to stand .Dressing intact to wound to BLE. Wound care is done twice weekly; reports severe pain with wound care. Will assess wounds further with dressing change Monday. Review of the EHR between 11/11/25 and 11/19/25 revealed no documentation to indicate wound assessments or treatments completed. The EHR lacked documentation to indicate provider notified of resident refusal to wound care on 11/17/25. Review of clinic notes from an Vascular Surgery appointment on 11/19/25 revealed, in part: HPI (History and Physical Information).Wounds noted on posterior aspect of bilateral ankle extending to lateral malleolus (bony knob on side of ankle) Associated with yellowish discharge on right lower extremity.Last dressing change was 9-days ago. The patient is unable to get dressing changes at subacute rehabilitation due to staffing issue. Scheduled for wound care appointment on 11/21/25.Assessment/Plan: Plan for right lower extremity angiogram with possible galloon angioplasty, follow up with wound care on 11/21/25, Regular care dressing at SNF (skilled nurse facility), ABX (antibiotic).Staff Physician Comments:. I met the patient for the first time on 11/19/2025. This is a 79 y.o. (year old) female who presents to clinic as a new patient for management of bilateral PVD R>L (peripheral vascular disease right greater than left). She is accompanied by her son and currently resides in [name of facility redacted] nursing facility. She was initially diagnosed with PVD in July 2025 when CTA (Computed Tomography Angiography – specialized imaging that uses X -ray and dye to create detailed pictures of blood vessels used for diagnoses) showed tibial (area on lower leg from knee to ankle) disease bilaterally. Today, she presents with a lateral right foot wound with evidence of surrounding erythema.She has unfortunately not had the best wound care at her nursing facility if any at all so we have provided recommendations (BID Vashe dressing changes) and also prescribed doxycycline (an antibiotic). Review of the After Visit Summary for the 11/19/25 Vascular Surgery appointment revealed the following Today's medication changes: a. Start taking doxycycline hyclate (antibiotic) for Open wound to right foot – 100 mg (milligram) capsule, 1 capsule by mouth 2 times daily for 10 days. b. Start taking sodium chloride-hypochlorous acid (VASHE, name brand of a wound wash) for Open wound of right foot – 0.033% topical solution, Apply 1 application topically 2 times daily. During an interview on 12/1/25 at 12:20 PM, Staff G, Registered Nurse (RN) stated that Resident #29's family may have been upset about wound treatments not getting done on her heels. Staff G confirmed that Resident #29 had admitted with wounds to bilateral ankles but had not personally assessed or provided wound cares/treatment as ordered to wounds. Staff G stated she was unable to get Resident #29's dressings done when scheduled to complete, but would ask the following shift to complete. During an interview on 12/2/25 at 10:45 AM, facility's Social Services Worker (SSW), stated that when speaking to Resident #29 after the Vascular Surgery appointment on 11/19/25, Resident #29 told SSW that the physician unwrapped her wound dressings, the wound was infected, and that the physician was upset that dressing change was not completed and family present at the appointment had started crying. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165287	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Specialty Care	451 West Orange Street West Branch, IA 52358

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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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/3/25 at 1:25 PM, Staff A, Licensed Practical Nurse (LPN) denied having personally assessed or performed wound treatments on Resident #29 but had documented on 11/17/25 that Resident #29 had refused wound cares, when Resident #29 shook her head no and stated no as Staff A entered her room. Staff A denied notification sent to the provider about wound treatment refusal. During an interview on 12/3/25 at 4:30 PM, the Director of Nursing (DON) revealed an expectation of staff to assess resident wounds and perform wound care and dressing changes as ordered. 2. Review of the MDS Assessment for Resident #2 dated 11/21/25, revealed a BIMS score of 11 out of 15, which indicated a moderate cognitive impairment. Diagnosis included esophageal obstruction, dysphagia, heart failure and chronic kidney disease. The MDS indicated Resident #2 dependent on staff to meet all of her needs due to cognitive deficits and physical limitations. The MDS documented that Resident #2 had a skin tear which required applications of ointments/medications. Review of the Care Plan, initiated on 4/17/25 and revised on 11/14/25, revealed a Focus area for Resident #2 of high risk for pressure ulcers to skin related to immobility, incontinence and end of life condition -skin tear left leg. Resident #2 would remain free from infection. Interventions included, in part: a. I need a full skin evaluation weekly with bath/shower. Date initiated 6/3//25. b. I need assistance with repositioning to avoid skin friction/shearing. Date initiated: 6/3//25. c. Monitor for changes in my skin status that may indicate worsening of my pressure ulcer and notify the physician. Date initiated: 7/22/25. Review of Skin and Wound Sheets revealed: a. On 11/13/25 – a left lateral calf skin tear with an onset date of 11/13/25, In-house acquired. Length 7.4 cm (centimeters); Width 4.23 cm; Depth 0.0 cm b. On 11/20/25 - skin tear length and width and noted to be stable. Length 5.36 cm; Width 2.7 cm; Depth 0.0 cm Review of the November 2025 Treatment Administration Record (TAR), revealed the following orders: a. Start Date 11/14/25, discontinued date 11/30/25 to cleanse wound on left lateral calf with wound cleanser, apply no sting barrier cover with high performance foam and non-adhesive dressing, securing with roll gauze and wound tape until healed. Change every 5 days and PRN. Review of the TAR revealed the treatment completed on 11/14/25, 11/24/25, and 11/29/25, with no documentation to indicate the 11/19/25 scheduled treatment completed. b. Start date 11/30/25 to cleanse wound on left lateral calf with wound cleanser, apply no sting barrier cover with high performance foam and non-adhesive dressing, securing with roll gauze and wound tape until healed. Change every 5 days and PRN as needed or if soiled, macerated or needing changed. Review of the TAR revealed no documentation on 11/30/25 to indicate the scheduled treatment completed. (continued on next page)

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	165287	A. Building B. Wing	12/03/2025

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an observation on 11/20/25 at 1:16 PM, Resident #2 assisted by Staff I, Certified Nursing Assistant (CNA), and Staff J, CNA with a full body mechanical lift for a transfer from her wheelchair to bed. After Resident #2 positioned into bed the CNA's assisted with changing the resident's incontinence brief. Upon removal of her pants, the wound on the residents left calf noted to be covered with a gauze dressing, which slipped off the wound area. The CNA's pulled the gauze back over the wound and proceeded to reposition the resident. During an observation on 12/2/25 at 4:40 PM, Staff M, LPN and the Traveling Director of Nursing (DON) donned gloves and gown to complete wound care. Staff M removed the dressing from the wound and stated the removed dressing was not correct per the physician order. Staff M explained a foam dressing should have been applied. Staff M proceeded to complete wound care per physician orders. During an interview on 12/2/25 at 5:00 PM, the facility DON queried wound care and stated he would expect all staff to follow Enhanced Barrier Precautions (EBP), follow the medical order and date and initial the dressing change. Review of the facility policy titled, Wound Care, dated October 2010, revealed a Purpose statement which declared: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Section A. Preparation directed, in part: a. Verify that there is a physician's order for this procedure. b. Review the resident's care plan to assess for any special needs of the resident. For example, the resident may have PRN orders for pain medication to be administered prior to wound care. Section C, Steps in the Procedure directed, in part: a. Apply treatments as indicated. Section E, Reporting directed, in part: a. Notify the supervisor if the resident refuses the wound care. b. Report other information in accordance with facility policy and professional standards of practice.

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	165287	A. Building B. Wing	12/03/2025

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	165287	A. Building B. Wing	12/03/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, staff interviews, clinical record review, and facility policy review, the facility failed to follow physician's orders for the treatment of a known facility acquired pressure ulcer and implement interventions to prevent a new pressure ulcer from developing for 1 of 2 resident (Resident #14) reviewed for pressure ulcers. Resident #14 admitted to the facility on Oct. 27, 2025, without pressure ulcers, and dependent on two staff assistance for bed mobility, transferring, and toileting assistance. Resident #14 assessed as at risk of the development of pressure ulcers. On Nov. 12, 2025, Resident #14 identified with a Stage 3 pressure ulcer on her sacrum. On Nov. 13, 2025, the primary care provider issued orders for wound treatments, an air mattress, and repositioning every 2 hours. During an observation on Nov. 19, 2025 at 8:45 AM, Resident #14 found to be without a dressing on the pressure ulcer, infection control techniques not utilized during wound care, physician orders not followed and the air mattress intervention not implemented. During a continual observation on Nov. 19, 2025 started at 1:26 PM until 4:20 PM, Resident #14 sat in a wheelchair, without reposition or toileting assistance. During an observation on Nov. 25, 2025 at 3:18 PM, Resident #14 found to be without a dressing on the pressure ulcer, a new open area on the coccyx, and the air mattress intervention not implemented. On Nov. 26, 2025, the primary care provider documented a new unstageable pressure wound overlying medial sacrum with yellow slough (sticky, non-viable) tissue. The facility reported a census of 58 residents. Pressure Staging:Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below).Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI.Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges),undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI.Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur.The State Agency informed the facility of the Immediate Jeopardy (IJ) on Dec. 01, 2025 at 11:30 AM. The IJ began on Nov. 12, 2025. Facility staff removed the immediate Jeopardy on Dec. 02, 2025 at 3:33 PM by implementing the following actions:1. Resident #14's new pressure ulcer assessed by provider on Nov. 25, 2025, provider reassessed wounds and treatment orders on Dec. 01, 2025. An air mattress was ordered on 11/25/25 and placed on Resident #14's bed on 11/26/25. Registered Dietitian reviewed Resident #14 and made dietary recommendations on 12/01/25.2. All nursing staff educated with verbal read back of education completed on Dec. 02, 2025, with training on the following: physician orders, pressure ulcer and pressure injury prevention, reporting, repositioning, and treatment. 3

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	165287	A. Building B. Wing	12/03/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record review and facility policy review, the facility failed to use safe transfer techniques to prevent falls or injury for 3 of 4 residents (Resident #3, Resident #7, and Resident #50) reviewed for transfer techniques. Resident #3 experienced a fall out of a mechanical lift on 7/25/25, which resulted in a hematoma, sacral fracture and tibia fracture. The facility further failed to complete neurological assessments and check for range of motion of extremities, following a fall for 2 of 4 residents (Resident #7 and Resident #15) reviewed for accidents and hazards. The facility reported a census of 58 residents. Findings include:1. Reviewed the Minimum Data Set (MDS), dated [DATE], revealed Resident #3 had severely impaired skills for daily decision making, with problems in both short-term memory and long-term memory. The list of diagnoses included Alzheimer's disease, bipolar disease, hip fracture, and other fracture. The MDS indicated Resident #3 dependent on staff for all care tasks, mobility, and transfers. The MDS identified that Resident #3 had one fall with major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma) since the previous assessment. Review of the Care Plan, initiated on 4/4/24, revealed a Focus area for Resident #3 at risk of falls related to decreased mobility with the goal that Resident #3 would not experience any major injuries related to falls. Interventions included, in part: a. Encourage me to sit in the common area while up in wheelchair. Date initiated: 5/07/2024. b. Encourage me to use my call light for assistance and ensure it is within reach. Date initiated: 4/04/2024. c. I have a soft touch call light. Date initiated: 6/26/2024. d. Utilize a winged mattress. Date initiated: 3/28/2025. Review of a Nurses Note, dated 7/25/25 at 7:25 PM, revealed Resident #3 transferred to her bed around 7:00 PM via full body mechanical lift and during the transfer, resident fell out of the lift landing on her knees and hitting her head. The note described that Resident #3 fell to her stomach, face down received a hematoma to the left side of her head and a laceration to her left upper facial area. Resident #3 unable to provide description of incident due to cognitive impairment and was sent out to the hospital by Staff M, Licensed Practical Nurse (LPN). Review of Nurses Note, dated 7/25/25 at 9:21 PM, revealed that the writer, Staff M, LPN heard a yell for help and ran to Resident #3's room right away, upon arrival Resident #3 found lying on the floor face down with the mechanical lift left leg underneath the resident. The note described the mechanical lift to be raised in the air with the sling still attached. The provider and resident's responsible party notified of incident and Resident #3 sent to the Emergency Department (ED) via ambulance. (continued on next page)

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	165287	A. Building B. Wing	12/03/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a Nurses Note, dated 7/26/25 at 2:40 AM, revealed Resident #3 returned from the hospital on 7/26/25 at 12:45 AM via ambulance. Resident has a sacrum fracture and tibial plateau (top of shin bone at the knee joint) fracture. Resident also has new orders for hydrocodone/acetaminophen (opioid pain medication) 5/325 mg (milligram) po (by mouth) every 8 hrs (hours) PRN (as needed for pain) and naloxone 4 mg 1 spray in each nostril, 98.7 (temperature), 88 (heart rate), 18 (respirations), 128/66 (blood pressure), 97% (oxygen saturation) on 4 liters oxygen. Per Nurses Note, dated 7/26/25 at 7:21 PM, Called to Resident's room to assess Resident by son at bedside, Resident sweating with damp hair and flushed face. Covers pulled back and reposition for proper alignment of torso and legs. Resident states in pain. Given pm meds with pain pill at this time. Will reassess in 10 minutes and with improvement of pain level will reposition on side and ADL (activities of daily living)/pm care will be rendered. Per Nurses Note, dated 7/26/25 at 7:31 PM, Call to on call provider to give change in condition to Resident. Call dropped. Per Nurses Note, dated 7/26/25 at 7:49 PM, Returned to room as Resident has thrown up projectile vomitus on self and foot of bed. VS (vital signs) taken BP 182/84, HR 135, O2 Sat at 86, R 14 shallow. While Resident being cleaned Call again to NP (nurse practitioner) and order received to send emergently to ER. Orders carried out. Per Nurses Note, dated 7/26/25 at 7:55 PM, 911 called for Resident transfer to ER Per Nurses Note, dated 7/26/25 at 8:05 PM, Fire department EMS (emergency medical services) here and Resident now has projectile vomits 3 more times, before transfer to stretcher and on to [name of hospital redacted] via 911 transport. Per Nursing Note, dated 7/27/25 at 10:28 AM, Received call from [name of hospital redacted} ER physician. Physician states that imaging suggests that resident may have inadvertently swallowed the crown of a tooth that may have episodes of vomiting last night. Resident remains at [name of hospital redacted] main campus. Review of a hospital Internal Medicine History and Physical note, dated 7/27/25, revealed in part: Chief Complaint: Hypoxia, Altered Mental Status. History of Present Illness:.Patient was seen in ED on 7/24/25 after she was dropped from a mechanical lift and sustained multiple sacral fractures, but was sent home [back to facility] later that day. Per the emergency department, the patient was noted to be less interactive by staff at nursing home during the day on 7/26/25.It is worth noting that there was radiopaque object seen in the stomach on her chest x-ray from 7/26, and a head CT (Computed Tomography, a type of imaging done for detailed body pictures) done on the same day showed a missing premolar implant.Imaging CT Head 7/26/25.No acute intracranial findings; Interval missing second mandibular premolar implant/crown with incompletely visualized mandible. Correlate for traumatic displacement given radiodense object in the stomach on the same day CXR (x ray image); Interval decreased left frontal scalp hematoma/contusion. (continued on next page)

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	165287	A. Building B. Wing	12/03/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Nurses Note, dated 7/27/25 at 4:03 PM, revealed Resident returned from visit to [name of hospital redacted] emergency room. Currently has O2 (oxygen) at 2 LPM (liters per minute) with 93% O2 saturation. Transported from [hospital name redacted] main campus by care ambulance via stretcher with 2 attendants. Received orders as follows: Discontinue arginine, atorvastatin, famotidine, folic acid, multivitamin with mineral and naloxone, son [name reacted] aware of all orders. Review of an incident report, dated 7/25/25 at 7:00 PM revealed that Resident #3 was being transferred to her bed around 7:00 PM via mechanical lift and during transfer had fallen out of the lift sling, landing on her knees and hitting her head. Resident #3 noted to fall down to stomach, found face down, and received a hematoma to the left side of her head and a laceration to her left upper facial area. Immediate action was to call emergency services and send Resident #3 to the hospital. During an interview on 12/01/25 at 9:00 AM, Staff N, Certified Nursing Assistant (CNA), confirmed she assisted Resident #3 with mechanical lift transfer on 7/25/25 after evening meal. Staff N explained that she hooked up Resident #3 to the lift cradle style which was described as leg straps being underneath Resident #3 in a U shape instead of crossing the leg straps between the legs in an X shape. Staff N reported that the left side leg strap was looped underneath both legs and the right leg strap was looped underneath both legs. Staff N stated that the full body slings were usually crossed between the legs, but was under the impression that the sling could be hooked up in a cradle style if the resident had stiff legs or contractions. Staff N reported that another CNA was in the room assisting Resident #3's roommate and Staff N started operating the mechanical lift while the other CNA finished assisting roommate in their bed. Staff N stated that Resident #3 fell out of lift soon after raising lift above the level of wheelchair. Staff N recalled that Resident #3 had been in a sitting position, with head slightly elevated in the sling when the mechanical lift was raised and resident's bottom half came out from sling. Staff N stated that Resident #3 fell out of sling feet first landing on her knees and bumped her head on the floor. Staff N reported that Resident #3 was turned a little bit while on the floor and was noted to have a large bruise on head and resident had complained of pain her knees and hip. Staff N recalled then yelling for other CNA in room to go get the nurse as she stayed with resident. Staff N stated following the incident she was asked to write a statement and was suspended for approximately 4 days, then received education about transferring with the lifts. Staff N informed that she was told by facility leadership that the sling was not hooked up wrong, according to manufacturer guidelines, but didn't end up being safe. During an interview on 12/02/25 at 10:00 AM, Staff M, Licensed Practical Nurse (LPN) confirmed working as charge nurse on the evening of 7/25/25 and was notified by a CNA that Resident #3 had fallen. Staff M recalled being confused on how Resident #3 could have fallen due to being a full body mechanical lift. Staff M stated she ran to Resident #3's room and observed resident lying on top of the mechanical lift legs with sling still completely attached to the lift and the lift raised up to highest level. Staff M stated that she asked CNA staff not to move Resident #3 as she went out to call Emergency Services and upon returning to Resident #3's room, found resident to have been moved/turned. Staff M reported that when asking CNA staff what had happened, she was told that Staff N operated the lift by herself while the second CNA in the room's back was turned assisting roommate. Staff M stated that the sling was not attached to the lift correctly, as it was in a cradle position, in which the leg straps were straight and should have been [NAME]-crossed between the resident's legs. During an interview on 12/03/25 at 4:30 PM, Director of Nursing (DON) stated he expected that all mechanical lift transfers have two staff present for safety. The DON revealed that incident was not reported to State Agency due to Resident #3 remaining at baseline for cognition, mobility, and pain. (continued on next page)

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	165287	A. Building B. Wing	12/03/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a Disciplinary Action form, signed by Supervisor and Staff N, CNA dated July 29, 2025, revealed that Staff N, CNA, disciplined for the violation of facility mechanical lift policy due to the fall that occurred on 7/25/25 when transferring Resident #3. Review of a Disciplinary Action form, signed by Supervisor and Staff P, CNA, dated July 30, 2025, revealed that Staff P disciplined for the violation of facility mechanical lift policy due to the fall that occurred on 7/25/25 when transferring Resident #3. Review of the Operator's Instructions for EZ Way Smart Lift (brand name of mechanical lift), revised on June 14, 2023, provided transferring instructions from chair, listed on pages 8 and 9, which directed, in part: The Section F. Transferring patient from chair, wheelchair, or toilet, instructed: Step 1 - Position Sling: a. Lean the patient forward several inches to place the sling behind the patient. b. With the sling handles and washing labels facing the chair back, place the sling behind the patient, keeping the center handle of the sling centered on the patient's spine. Make sure the base of the sling touches the chair seat and is two inches below the tailbone. Make sure the top of the sling is above the patient's shoulders and lean the patient back in the chair. c. Pull the legs of the sling along inside of the chair. d. To set the sling properly, you must do the following: On the patient's right side, position your right hand between the patient's hip and the sling. With your fingers, push down on the edge of the sling so it touches the base of the chair seat. Next, grasp the bottom edge of sling leg with your left hand and pull with a tug towards you. e. Lift the patient's left knee with a tug, ull the leg of the sling under the hip and thigh. Place the excess sling length over the left thigh. f. Repeat this procedure on the right side. This procedure will ensure the sling is under the patient's tail bone and behind his/her back, with the patient's weight evenly distributed on the sling. Step 3 - Attach sling to the lift: a. Take the sling leg that is lying over the patient's left thigh and attach it to the right hook on the hanger bar. b. Take the sling leg lying over the right thigh and attach it to the left hook on the hanger bar, again using the same length and color of loop strap on each side. c. Attach the straps located near the patient's shoulders to the lift hanger bar hooks, using the same length and color of loop strap on each side. Example: If you choose the shortest loop on the strap for the right shoulder, you must use the shortest loop on the strop for the left shoulder. (continued on next page)

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	165287	A. Building B. Wing	12/03/2025

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Crestview Specialty Care	451 West Orange Street West Branch, IA 52358

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Step 4 - Lifting the patient a. Push the UP button on the hand control to initiate the upward motion of the lift. Continue the upward motion until there is tension on the legs of the sling, making sure all the loops on the sling are securely hooked on the hanger bars. b. Smooth the sling legs under the patient's thighs with a slight pull on the outside seam of the sling legs, if necessary. c. Lift the patient to the desired height (usually 2-3 inches above the chair) Step 5 - Transferring the patient a. Ensure there are no obstruction in the path of travel. b. Pull or push the lift using the operator's handles on the lift mast. Maneuver the lift to a desired location. 2. Review of the MDS assessment, dated 9/29/25, revealed Resident #7 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment. The list of diagnoses included Alzheimer's disease, respiratory failure, hypertension, anxiety disorder, and other (unlisted) type of fracture. Review of the Care Plan, date revised on 9/04/25, revealed a Focused area for Resident #7's risk for falls related to decreased mobility and inability to bear weight to the left wrist, with the goal that Resident #7 would not sustain serious injury through the review date. Interventions included, in part: a. Sign added to walker to remind Resident #7 to use and call for help. Date initiated: 8/29/25. b. Encourage Resident #7 to wear grippy socks versus slick socks if she chooses to walk with no shoes on. Date initiated: 6/23/25. c. Ensure that Resident #7 is wearing appropriate footwear. Date initiated: 1/05/24. d. Non-skid strips applied beside the bed and chair. Date initiated: 3/11/25. e. Physical Therapy to evaluate and treat as ordered or as needed. Date initiated: 1/05/24. f. Utilize a soft touch call light. Date initiated: 3/11/25. Review of the Care Plan, date initiated 1/05/24, revealed a Focused area for activities of daily living which identified the following interventions, in part: a. Assistance of one staff for ambulation with hand hold, no walker at this time related to wrist fracture. Date revised: 9/03/25. b. One staff assistance to stand and pivot transfer between surfaces. Date revised: 9/03/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	c. Non weight bearing status to left upper extremity. Date initiated: 9/04/25. During an observation on 11/19/25 at 9:01 AM, Resident #7 began to stand from the dining room table, Staff R, CNA, noticed and approached Resident #7. Staff R pulled the dining room chair away from table as Resident #7 stood, no gait belt was applied to assist the resident with safety/stability prior to initiating ambulation assistance. Resident #7 fell onto her bottom and another staff member present in the dining room went to notify the nurse of the fall. At 9:05 AM, several staff members entered the dining room, which included the charge nurse for Resident #7, Staff G, RN. Staff brought in a wheelchair and gait belt to assist with getting Resident #7 up from the floor. Nursing staff completed a check of Resident #7's neurological status and vital signs, no Range of Motion (ROM) of extremities checked, to assess for pain or difficulty moving the upper or lower extremities before moving the resident. Three staff used a gait belt and assisted Resident #7 to a standing position, the fourth staff brought a wheelchair behind the resident to sit in, then transported the resident to her room via wheelchair. During an interview on 11/19/25 at 9:15 AM, Staff R, CNA stated when she pulled the dining room chair back, Resident #7 just went down and bumped her chin on the table. Staff R reported that Resident #7 stated she felt dizzy and complained of back pain post fall. When queried if either nurse assessed Resident #7's ROM before moving the resident, Staff R stated that nurses had felt the resident's arms and legs before assisting her off the floor. During an interview on 11/19/25 at 9:20 AM, Staff G, RN, stated she did not personally perform a check of Resident #7's ROM and was unsure if the other nurse present had checked Resident #7's ROM before assisting the resident up from the floor. Review of an incident report completed by Staff G, RN, dated 11/19/25 at 9:00 AM, documented that Staff G was notified of a fall in the dining room that occurred when a staff member was assisting Resident #7 to get up from the table and go back to her room. The incident report revealed that Resident #7 complained of being very dizzy, became weak, and was lowered to the floor. The report informed that Resident #7 complained of her back hurting, was dizzy, and did not feel well. Three staff assisted Resident #7 up from the floor using a gait belt and assisted her into a wheelchair, then transported the resident to her room. Staff G documented that Resident #7 was found to have a very low blood pressure and was assisted to lay in bed with feet elevated. Staff G documented that neurological assessments would be followed per guidelines and that provider was notified of the incident. Review of Resident #7's documented vital signs revealed that on 11/19/25 at 9:21 AM, the blood pressure reading was 60/35 and at 9:23 AM, the blood pressure reading was 76/43. Review of Resident #7's list of assessments, revealed a Neurological Evaluation (check of mental status/alertness, cranial nerves, motor skills, sensory perception, reflexes, coordination, and gait used for early detection of changes that may be related to a head injury) was initiated on 11/19/25. Review of the Neurological Assessment initiated on 11/19/25, revealed that an initial neurological assessment was completed and that the follow up assessments had been left incomplete. Review of a Skin Assessment, dated 11/21/25, revealed a new bruise to Resident #7's right chin that measured 1.68 centimeters (cm) length, by 1.81cm in width. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/20/25 at 11:00 AM, Staff S, CNA, reported that Resident #7 required one staff assistance using a walker and gait belt to transfer and ambulate. Staff S working on Resident #7's hallway was unaware of Resident #7 having any recent falls or incidents. During an interview on 11/20/25 at 11:35 AM, Staff G, RN, identified that the facility's fall protocol included assessing the resident for pain, injury, dizziness, ROM, and complete neurological checks if the resident hit their head. Staff G reported that Resident #7 required the assistance of one staff member to transfer using a gait belt due to losing balance at times and history of falling. Staff G stated that the follow up from Resident #7's fall on 11/19/25 included monitoring for dizziness, continuing to complete neurological assessments, and provider notification. Staff G confirmed that Resident #7 obtained a bruise on her chin during the fall on 11/19/25. During an interview on 12/02/25 at 4:30 PM, the DON revealed the expectation of nurses to check a resident's ROM prior to moving a resident post fall. The DON stated neurological assessments would be completed per protocol for unwitnessed falls and falls in which the resident hit their head. 3. Review of the MDS assessment, dated 10/03/25, revealed Resident #15 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment. The list of diagnoses included Non-Alzheimer's dementia, schizophrenia, and congestive heart failure. Review of the Care Plan, initiated on 5/29/24 and revised on 11/26/25, revealed the Focus area: I am at risk for falls. I prefer to crawl on the floor for mobility at times as I am unsteady to walk. I do not wait for assistance for transfers or use call light. Interventions included, in part: a. Encourage me to use my call light for assistance. Date initiated: 5/29/24. b. I need a safe environment without clutter. Date initiated: 11/26/25. c. Offer resident toileting assistance before and after meals. Date initiated: 5/26/25. d. Reminder sign in bathroom to call for help. Date initiated: 9/15/25. e. Reminder sign in room to call for help with transfer. Date initiated: 9/22/25. Review of the Care Plan, initiated on 1/19/24, revealed a Focus area for Activities of Daily Living (ADLs) with the goal that Resident #15 would continue to participate during ADLs as condition allows. Intervention included, in part: a. Independent with wheelchair mobility. Date initiated: 1/19/24. b. One staff assistance with bed mobility. Date initiated: 1/19/24. c. One staff assistance with toileting. Date initiated: 1/19/24. d. One staff assistance with transfers using the walker. Date initiated: 1/19/24. e. One staff assistance with upper and lower body dressing. Date initiated: 1/19/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing note, dated 11/15/25 at 5:19 AM, revealed Staff T, LPN, documented that Resident #15 was observed on the floor near his bed and wheelchair. The note informed that Resident #15 had been incontinent of urine, was noted to be gathering clothing and stated he didn't fall. The note revealed that Resident #15 denied pain, had full ROM per his baseline, refused check of vital signs, and Care Plan reflected that resident likes to crawl on the floor at times. Review of Resident #15's list of assessments performed, revealed that a Fall Risk Evaluation was completed on 11/26/25. The list of assessments revealed that a Neurological Evaluation was not initiated on 11/25/25. Review of a Fall Risk Evaluation, dated 11/26/25, documented a score of 14, which indicated that Resident #15 was at high risk for falls. The fall evaluation identified that Resident #15 had intermittent confusion, 3 or more falls in the past 3 months, was chair bound, had a change in medication within the previous 5 days, and had 3 or more predisposing diseases that put him at risk for falls. During an interview on 12/03/25 at 3:00 PM, Staff T, LPN, confirmed documenting Resident #15 had been observed on the floor in his room on 11/26/25 at 5:19 AM. Staff T stated that she received education from the facility following this documentation, that although Resident #15's Care Plan identified that he liked to crawl on the floor at times, finding him on the floor would still be considered an unwitnessed fall and protocol for an unwitnessed fall should have been followed. Staff T stated that going forward, she would follow protocol for an unwitnessed fall in this situation. During an interview on 12/03/25 at 4:30 PM, the DON reported that Resident #15 required one staff assistance with transferring and toileting. The DON revealed an expectation that neurological evaluations are completed following an unwitnessed fall. #4. The MDS for Resident#50 dated 10/3/25, listed diagnoses of non-traumatic brain dysfunction, non-Alzheimer's dementia, osteoporosis, and hip fracture. The MDS reflected Resident #50 dependent on 2 or more staff for chair-to-chair transfer. The BIMS identified a score of 3 out of 15, severe cognitive impairment. The Care Plan for Resident#50 dated 9/28/23, included Activities of Daily Living (ADL's) revision on 11/28/2023 directed she required maximum assistance of 2 with walker for transfers. During an observation on 12/02/2025 at 9:18 AM, Staff K, CNA in the east lounge stood in front of Resident #50, reached her arms under Resident #50 arms as Resident #50 sat in her wheel chair and lifted Resident #50 and completed a stand pivot transfer (SPT) without a gait belt in to the recliner in the lounge. During an interview on 12/02/2025 at 9:20 AM, the Traveling Director of Nursing (DON) reported she expected the staff to use a gait belt (GB) with SPT. During an interview on 12/02/2025 at 9:22 AM, Staff K, CNA confirmed she alone transferred Resident#50 from the wheel chair to the recliner in the East lounge and failed to use a GB. She reported other staff asked her to move Residnet#50 into the recliner and she just moved her. During an interview on 2/03/2025 at 2:22 PM, the Administrator reported she expected the staff to transfer residents according to their Care Plan and use a GB. during a SPT. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Safe Lifting and Movement of Residents, dated 7/2017, revealed a Policy Statement which declared In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. The Policy Interpretation and Implementation section policy directed, in part: a. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. b. Manual lifting of residents shall be eliminated when feasible. c. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: Resident's preferences for assistance; Resident's mobility (degree of dependency); Resident's size; Weight-bearing ability; Cognitive status; Whether the resident is usually cooperative with staff; and the resident's goals for rehabilitation, including restoring or maintaining functional abilities. d. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. e. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. f. All equipment design and use will meet or exceed guidelines and regulations concerning resident safety and the use of restraints. g. Safe lifting and movement of residents is part of an overall facility employee health and safety program, which: Involves employees in identifying problem areas and implementing workplace safety and injury-prevention strategies; Provides training on safety, ergonomics and proper use of equipment; and continually evaluates the effectiveness of workplace safety and injury-prevention strategies. Review of the facility policy titled, Neurological Assessment, revised Oct. 2010, revealed a Purpose Statement to provide guidelines for a neurological assessment: 1. Upon physician order; 2. When following an unwitnessed fall; 3. Subsequent to a fall with suspected head injury; or 4. When indicated by resident condition. The General Guidelines, section directed: a. Neurological assessments are indicated: upon physician order; following an unwitnessed fall; following a fall or other accident/injury involving head trauma; or when indicated by the residents condition. b. When assessing neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure (ICP). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	c. Any change in vital signs or neurological status in a previously stable resident should be reported to the physician immediately. Review of the facility policy titled, Falls- Clinical Protocol, dated March 2018, revealed a Assessment and Recognition section, which directed, in part: a. The nurse shall assess and document/report the following: Vital signs; Recent injury, especially fracture or head injury. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; Neurological status; Pain; Frequency and number of falls since last physician visit; Precipitating factors, details on how fall occurred; All current medications, especially those associated with dizziness or lethargy; and All active diagnoses. b. Falls should be identified as witnessed or unwitnessed events.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on clinical record review, facility policy review and staff interviews, the facility failed to provide enough qualified staff members to provide nursing and related services to meet the specific, individualized needs for 1 of 2 residents reviewed for sufficient staff (Resident #6). The facility reported a census of 58 residents. 1. The Minimum Data Set (MDS) Assessment for Resident #6 dated 6/13/25, reflected a Brief Interview for Mental Status (BIMS) of 9 out of 15, indicating moderate cognitive impairment. The MDS identified Resident #6 required moderate assistance for toileting, bathing and personal hygiene. Resident #6 is frequently incontinent and the resident is not on a toileting program. The Care Plan for Resident #6 dated 7/5/24, and revised on 7/15/25, revealed activities of daily (ADL) self-care deficit which required moderate assistance for bathing and partial assistance for personal hygiene. Review of ADL Self Care-Shower/Bath Sheet revealed Resident #6 did not receive a bath or shower from 11/14/25 through 11/30/25 a period of 17 days. During an interview on 11/12/25 at 2:10 PM, Staff D, Certified Nursing Assistant (CNA) stated they do not have enough staff scheduled on a routine basis and are not able to get all of their personal care completed. It has been brought to management's attention numerous times and nothing changes. During an interview on 11/12/25 at 4:40 PM, Staff G, Registered Nurse (RN),she stated there is definitely a lack of staff working at the facility at any given time. All of the shifts need additional certified nursing staff working. She stated not all of the resident cares can get done with the lack of staff on some shifts. Staff G stated she has reported cares not getting done to management including the Director of Nursing, (DON) numerous times and has not noticed a difference. 2. During an interview on Nov. 25, 2025 at 3:18 PM, Staff A, Licensed Practical Nurse (LPN), worked on the 200 hallway from 6:00 AM to 6:00 PM, reported she had been unable to complete scheduled AM wound care treatments when a medication aide was not scheduled, due to being tasked with passing medication in addition to charge nurse duties. During an interview on Dec. 01, 2025 at 12:20 PM, Staff G, Registered Nurse (RN), reported that at times she would need to pass on wound treatments to the next shift when unable to complete due to being without a medication aide or assisting CNA staff, if short staffed, to complete care tasks. During an interview on Dec. 01, 2025 at 9:00 AM, Staff N, CNA, worked on the 2:00 PM to 10:00 PM shift and reported that she would often be the only CNA available for a hallway, with approximately 25 residents, many of which required 2 staff members to assist with mechanical lift transfers. Staff N notified that there had been times on 2nd shift in which all residents would receive a room tray for supper due to not enough staff available to get residents up to the dining room and residents who required feeding assistance would be helped in their rooms one at a time. Staff N stated that 5 resident baths would be scheduled on her shift and when only one or two CNAs worked, the baths would not always be completed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/18/25 at 4:15 PM, the Administrator stated she is new to this position but staffing concerns are one of her top priorities. She is aware that low staffing numbers have been a concern in the building. Review of the Facility Assessment, dated Dec. 01, 2025, revealed: a. Section titled: Daily staffing patterns, identified that daily staffing patterns were consistent based on the census of residents and additional staff would be scheduled as needed related to resident needs and acuity. The section identified the following: Staffing is based on the residents' acuity and staffing strengths; Department Heads are assigned a Quality Assurance checklist for portions of the building weekly, including call light audits. On weekends, the Weekend Manager performs call light audits and door alarm checks. b. Section titled: Contingent Staffing, revealed that the facility has a process to assess staffing levels based on employee call outs due to illness or unforeseen circumstance and directed the following: The charge nurse notifies the specific department head of the call in as soon as possible. Dietary and Environmental handle calling in their employees that are off or filling the shifts as needed. The DON and scheduler begin calling all employees that are off and filling in the calendar to request additional nursing staff through staffing agencies. In the interim the DON/Designee directs a supervisor to help until other staff can be called in. Nursing staff will be directed by their charge nurse to change assignments as needed to fulfill the needs of the residents until proper staffing levels can be obtained.