

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Crestview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 South Des Moines Street Webster City, IA 50595	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interview and policy review, the facility failed to treat residents (Resident #6 and Resident #18) with dignity during meal service. The facility reported a census of 58 residents. Findings Include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #6 had a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The resident had diagnoses of other orthopedic conditions, cirrhosis, renal insufficiency and non-Alzheimer's dementia. The MDS documented the resident required substantial/maximal assistance with eating. The Care Plan for Resident #6, with a revision date of 10/7/24, included a focus area the resident will need help to complete Activities of Daily Living (ADL's) daily due to weakness. The Interventions instructed staff Resident #6 could eat independently after setting up. During a continuous observation of lunch service in the Chronic Confusion or Dementing Illness (CCDI) unit on 9/15/25 beginning at 12:00 PM, Staff C, Certified Nursing Assistant (CNA), stood over Resident #6 while helping her eat. Staff C brought bites of food on a fork to Resident #6's mouth and bringing the cup of fluid to the resident's mouth. Staff C did not sit next to the resident and stood over her for the entirety of the lunch service helping them eat. During an observation 9/16/25 at 11:45 AM of lunch service in the CCDI unit, Staff C stood over Resident #6 and brought food to their mouth on a fork. As Staff C assisted Resident #6 eat her lunch, they stood over her. 2. The MDS dated [DATE] documented Resident #18 had a BIMS score of 0, indicating severe cognitive impairment. The resident had diagnoses hyperlipidemia (high bad cholesterol) and non-Alzheimer's dementia. The MDS documented the resident required set-up or clean-up assistance with eating. The Care Plan for Resident #18, with a revision date of 10/7/22, included a focus area that the resident needed help to complete ADL's daily due to dementia. The Intervention instructed staff to set-up assist for eating and documented the resident as independent with eating. During a continuous observation of lunch service in the CCDI unit on 9/15/25 beginning at 12:08 PM, Staff D, CNA, stood over Resident #18 as they assisted them eat lunch. Staff D brought food to the resident's mouth with a fork and brought a cup with fluid to the resident's mouth. Staff D stood over the resident for the entire lunch service, assisting the resident with eating and drinking. During an observation 9/16/25 at 11:53 AM of lunch service in the CCDI unit, Staff C, CNA, went over to Resident #18, put food on a fork and brought it to their mouth, while standing over her. Staff C brought several bites of food to Resident #18's mouth, all while standing over her, as well as the glass for a drink. Staff C stood over the resident to assist with eating until 11:59 AM. At 12:03 PM, Staff C returned to the resident, stood over them, put food on a fork and brought it to their mouth. During an observation 9/17/25 beginning at 11:45 AM of lunch service in the CCDI unit, Resident #18 ate her meal independently. During an interview 9/17/25 at 12:35 PM, the Director of Nursing (DON) stated they expected the staff to sit down next to residents while assisting them during meal services and not hover over them as they assisted them with eating and drinking for dignity purposes. Review of the facility policy Promoting/Maintaining Resident Dignity During Mealtimes, undated, documented it is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life. All staff will be seated, if possible, while feeding a resident.		

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to submit a Level 1 and a Level II Preadmission Screening and Resident Review (PASRR) evaluation to the appropriate state-designated authority prior to the expiration date for 2 of 2 residents reviewed for PASRR (Resident #4 and Resident #38). The facility reported a census of 58 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] indicated Resident #4 had diagnoses of anxiety disorder, depression and bipolar disorder. Resident #4's PASRR completed [DATE] provided authorization for short-term nursing facility services approved for 60-days for convalescent care. The report also indicated that re-screening must occur by or before the 60th day if the individual would remain in the nursing facility beyond the current authorized timeframe. The due date of the Follow-up level I PASRR would need done on or before [DATE]. In an interview on [DATE] at 1:05 PM Staff A, Social Worker (SW), stated PASRR assessments are typically done by the hospital before they first arrive at the facility. She typically performed them when there is a change in condition or a new diagnosis, especially for Level II PASRR residents. Staff A stated the authorized PASRR company tracked when the next PASRR is due online. Upon request of Staff A reviewing Resident #4 online, she described Resident #4 as a short term PASRR that she missed and is overdue for one now. Staff A reported the last PASRR performed as [DATE] and only approved for 60 days. Added Resident #4 should have a new level I PASRR completed just after the first of the year, and she planned to complete it soon. In an interview on [DATE] at 9:00 AM Staff A explained she currently worked on Resident #4's new PASRR level I. She stated she would expect to get a reply in 12-24 hours but expected Resident #4 would be a level II. She added that if Resident #4 received a level II indicated, someone would come out and evaluate her on site. When questioned about Resident #4's PASRR status as level I or level II, Staff A responded neither as she is out of compliance. A document titled Resident Assessment & Coordination with PASARR Program stated that the Social Services Director, or designee, shall be responsible for keeping track of each resident's PASRR screening status, and referring to the appropriate authority. 2. The MDS dated [DATE] documented Resident #38 had a BIMS score of 7, indicating severe cognitive impairment. The resident had diagnoses to include medically complex conditions, anxiety disorder and bipolar disorder. The MDS documented the resident was taking high risk drug classes to include antipsychotic and antianxiety medications in the look back period. The Care Plan for Resident #38, with an initiation date of [DATE], documented they received a short-term nursing facility approval in PASRR which expired [DATE], as a result all PASRR identified community placement supports needed addressed as part of the resident's Care Plan in addition to any specialized and rehabilitative services. Clinical record review of facility submitted Level II PASRR completed by the authorized facility for Resident #38 documented a determination of a short-term Level II approval on [DATE], with a time (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited approval of [DATE]. Clinical record review for Resident #38 lacked a new Level II PASRR submission before or after the approval end date of [DATE]. During an interview on [DATE] at 2:30 PM, Staff A verified the date of the last Level II PASRR completed for Resident #38 as [DATE], with a Level II short term approval that expired on [DATE]. Staff A acknowledged another PASRR didn't get completed in November of 2023 or since then. Staff A explained they expected this completed and submitted by the expiration date in [DATE].		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to fully review and revise the comprehensive Care Plan for 2 of 16 residents (Resident #4 and Resident #38) sampled for Care Plan review. The facility reported a census of 58 residents. Findings include: 1. Resident #4 had a Preadmission Screening and Resident Review (PASRR) completed on [DATE], which provided authorization for short-term nursing facility services approved for a 60-days for convalescent care. The report also indicated that re-screening must occur by or before the 60th day if the individual would be remaining in the nursing facility beyond the current authorized timeframe. Follow-up level I PASRR would be due on or before [DATE]. The Care Plan initiated on [DATE] for Resident #4 referenced PASRR level II 3 times including goals and interventions. It was noted, after speaking with Staff A, SW, that the PASRR level II references on the Care Plan were cancelled on [DATE]. In an interview on [DATE] at 1:05 PM Staff A, SW stated PASRR assessments are typically done by the hospital before they first arrive at the facility. She typically performs them when there is a change in condition or a new diagnosis, especially for Level II PASRR residents. Staff A, SW stated that Maximus tracks when the next PASRR is due online. This surveyor requested she pull up Resident #4 online. Staff A, SW stated that she was a short term PASRR that she missed and is due for one now. Stated the last PASRR performed was [DATE] and was only approved for 60 days. Added that she should have been due just after the first of this year and she plans to do soon. In an interview on [DATE] at 9:00 AM Staff A stated that 3 references to PASRR level II on the Care Plan is probably from her previous stays. When questioned if they should be on the current Care Plan given Resident #4's status, she stated no they shouldn't. An undated document titled Care Plan Revisions Upon Status Change instructed to review and revise the Comprehensive Care Plan as necessary, when a resident experiences a status change. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #38 had a BIMS score of 7, indicating severe cognitive impairment. The resident had diagnoses of medically complex conditions, anxiety disorder and bipolar disorder. Clinical record review of facility submitted Level II PASRR for Resident #38 documented a determination of a short-term Level II approval on [DATE], with a time limited approval of [DATE]. The PASRR determination explanation section documented the resident met PASRR criteria for serious mental illness which had led to significant symptoms that impact daily functioning and the need for intensive supports. The PASRR included what services and supports the nursing facility staff were required to provide, which included the following specialized services: ongoing psychiatric medication management, individual therapy by a licensed behavioral health professional, rehabilitative services and community placement supports. The Care Plan for Resident #38, with a revision date of [DATE], included a focus area for PASRR. The Care Plan documented PASRR had identified the resident was in need of specialized services due (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to mental illness and to assist the resident to achieve optimal functioning and recovery. The interventions/tasks section did not provide the name of the therapist or the frequency of therapy. The Care Plan further documented the resident had been given a short-term nursing facility approval in PASRR which expired [DATE], as a result all PASRR identified community placement supports needed addressed as part of the resident's Care Plan in addition to any specialized and rehabilitative services. During an interview [DATE] at 3:25 PM, Staff A stated she completed the residents' Care Plans on PASRR. In addition, she updated and revised those sections. She acknowledged Resident #38's Care Plan section didn't get updated since 2023 regarding the PASRR recommendations or revised to be person-centered. The facility used a template for PASRR, and the template didn't get updated for specific interventions for Resident #38. Staff A stated they expected that updated, revised, be person centered and comprehensive. Staff A acknowledged this didn't happen with Resident #38's Care Plan.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical chart review and staff interview the facility failed to check placement for jejunostomy tube (j-tube or a small tube inserted through the stomach to provide nutrients and potential medication) for 1 of 1 resident (Resident #1). The facility reported a census of 58 residents. Findings included: The Minimum Data Set (MDS) dated [DATE] for Resident #1, documented the Brief Interview for Mental Status (BIMS) scored a 13 indicating intact cognition. The MDS identified diagnoses of quadriplegic (inability to move their upper and lower body on their own), seizure disorder, and peripheral vascular disease (poor blood flow through the vessels). The MDS indicated Resident #1 received nutrition through a jejunostomy feeding tube. The Care Plan dated 5/20/25 indicated to check for tube placement and gastric contents/residual volume per order. On 9/17/25 at 11:10 AM observed Staff B, Registered Nurse, (RN), administer medications and fluids via the j-tube. Staff B failed to check placement of the j-tube prior to administering the medications or fluids. Interview on 9/17/25 at 12:15 PM Staff B, acknowledged she didn't check placement prior to administering the fluids. Staff B verified the nurse would check placement by pulling back the stomach contents. The facility policy dated 5/5/25 named Verifying Placement of Feeding Tube identified the practice of the facility as to ensure proper placement of feeding tubes prior to beginning a feeding, flushing the tube, or before administering medications via feeding tube. To verify tube placement, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. Notify supervisor and/or physician of abnormal findings, or using a stethoscope, listen for placement. Place the stethoscope's diaphragm flat on the patient's abdomen, next to the tube site. Quickly inject air (5-10 milliliters ML) down the tube, listen for a swoosh or gurgling sound. On 9/17/25 at 12:50 PM the DON stated they expected the staff to follow the physician orders on the medication administration sheet and to check placement prior to administering fluids.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, document review and staff interviews the facility failed to provide appropriate infection prevention practices by not following guidelines for enhanced barrier precautions (EBP) for 1 out of 1 resident reviewed (Resident #1). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #1, documented the Brief Interview for Mental Status (BIMS) scored a 13 indicating intact cognition. The MDS listed Resident #1 utilizes an external catheter. The MDS identified diagnosis as a quadriplegic, seizure disorder, and peripheral vascular disease. The MDS also documented that the resident received nutrition through a jejunostomy feeding tube (j-tube). Resident #1's Care Plan dated 7/25/25 instructed staff to wear EBP due to their indwelling j-tube and urinary catheter. On 9/17/25 at 11:10 AM observed Staff B, Registered Nurse (RN), complete a treatment to Resident #1's j-tube site. As Staff B did, they treatment, they failed to wear EBP. Interview on 9/17/25 at 12:15 PM Staff B acknowledged she should have worn EBP while doing the treatment. The facility policy named Enhanced Barrier Precautions revised 5/8/24 defined the purpose as to reduce the risk of transmission of multidrug-resistant organisms (MDRO) in the facility. High Contact activity included activities that place the resident and the person helping them in close physical contact that increases the risk of transmission of MDRO between the resident and health care provider. These activities included device care such as central line, urinary catheter, feeding tube, and tracheotomy/ventilator. Indwelling devices include any devices that are inserted into the resident and have contact with the external air such as foley catheters, central lines, tracheostomies, feeding tubes, or drains. Personal protective equipment (PPE) used to reduce the risk of exposure to and transmission of microorganisms. EBP includes the use of gowns and gloves. In instances where splashes/sprays are anticipated, face protection (mask or respirator) and eye protection (goggles or face shield) should also be applied. Interview on 9/17/25 at 12:50 PM the Director of Nursing (DON) stated they expected the staff to wear EPB for residents with feeding tubes and catheters.		