STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165165	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northcrest Specialty Care	2001 Heath Street Waterloo, IA 50703

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 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** 20331 Based on clinical record review, staff interview, and observation the facility failed to provide appropriate assessment and intervention for one of three residents reviewed (Resident #1). The facility reported a census of 79 residents. Findings include: The admission MDS (Minimum Data Set) an assessment tool dated 2/26/2024 revealed Resident #1 had mild impaired cognitive abilities, required staff assistance to transfer from one surface to another, used a wheel chair for mobility, and had no identified skin concerns. The MDS revealed the resident had diagnoses including anemia, malnutrition, ESRD (End Stage Renal Disease), diabetes, heart failure and received dialysis. The quarterly MDS dated [DATE] revealed the resident had intact cognitive abilities, required staff assistance to transfer, and received ointment/medication application other than to feet. The Care Plan identified the resident had a skin integrity concern due to venous insufficiency dated 3/12/2024. It directed staff to monitor the resident to avoid scratching, keep fingernails short, provide good nutrition, administer treatments as ordered, and staff were to do weekly skin assessments and document width, length, type of tissue, and other notable change. The TAR (Treatment Administration Record) dated 2/22/2024 - 5/21/2024 instructed staff to complete a head to toe skin check on the 2 - 10 o'clock P.M. shift on Thursday even if a previous skin area has been noted. If a new skin concern is noted, complete a new Risk Management, skin evaluation and add or update the weekly non-pressure/pressure Good Nursing Order. The resident's May, 2024 MAR/TAR (Medication and Treatment Administration Records) revealed an order for Benadryl itch stopping external cream on 5/21/2024. The records revealed staff failed to administer the cream from 5/21/2024 through 5/29/2024. The Resident's April, 2024 Weekly Skin Evaluation revealed staff documented they performed a skin evaluation on April 4, April 11, and April 18. Staff failed to perform the skin evaluation on April 25. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Resident's May, 2024 Weekly Skin Evaluation revealed staff documented they performed a skin evaluation on May 24. Staff failed to perform the skin evaluation on May 2, May 9, and May 16 as they were instructed. The resident's clinical record included skin evaluations related to a right shin skin issue from 3/5 - 4/11/2024. On 4/11/2024 the area had no measurement, indicating the wound had healed. The resident's clinical record had no further skin evaluations related to the residents lower extremities. The Resident's Progress Notes included: 4/19/2024 - Red/pink rash to bilateral abdominal folds, groin and under bilateral breasts. Appears yeast related with foul odors, and no bleeding or open areas. Areas cleansed with soap and water, barrier applied and Impact (the resident's primary care physician clinic) notified. The resident received a new order for Nystatin powder (treats yeast or fungal infections) for ten days. 4/27/2024 - resident picking at right lower extremity this shift resulting in leg bleeding. Wrapped legs per treatment order. Family visiting and questioned if treatment had been done and about the color of bilateral legs. The writer assured family the treatment had been done and the resident's picking had caused the bleeding. The resident stated she had picked the scales on her leg. The writer educated family the color to her bilateral legs was normal and due to chronic kidney disease. The writer wrapped the legs with new roll gauze. The family indicated the resident had medication at home for pruritis (itchy skin) and would let the facility know which specific medication. 4/30/2024 - New orders from Impact: , discontinue current treatment and apply Eucerin cream and tubigrips (tubular bandage). 5/19/2024 - Resident has red, irritated rash to abdominal folds and looks like yeast rash. Impact called and requested an order for Nystatin powder BID (two times a day) until healed. Education provided to C.N.A.'s to ensure resident's abdominal folds are cleansed and dried with every check and change or incontinence episode. 5/20/2024 - New order: Nystatin to abdominal folds. 5/20/2024 - Resident complained of itching and current medications are not helping with itch relief. Impact office called and voicemail left requesting a PRN (as needed) order to help with increased itching. 5/21/2024- Resident has been complaining of itching and states she wants an itch pill. Impact called and received orders for Benadryl cream BID and PRN. They are also going to check with primary nurse practitioner about getting Benadryl tablet order for all over itching. 5/27 and 5/28/2024 - Resident refused Nystatin and Eucerin lotion. 5/28/2024 at 4:55 A.M. - bilateral lower extremities with red/weeping blisters shin to calf. Yellow/red drainage. Resident observed scratching legs. Bilateral lower extremities covered with dressing to deter resident from scratching. Impact called. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	5/28/2024 at 11:16 A.M. - Changed dressing to lower legs, no bleeding but open with sanguineous fluid (containing blood). Cleaned them and placed new dressing. Called Impact and indicated the wound nurse would see the resident on 5/29/2024. Also, brought up the Hydroxyzine the resident stated she took in the past. 5/28/2024 at 1:16 P.M. - Impact wound nurse will see resident tomorrow. 5/28/2024 at 10:05 PM. - Call placed to Impact due to resident's leg wound. Unable to take a photo due to I-pad not working. Received a new order: Xeroform (dressing) to weeping areas, (ABD) absorbent dressing, wrap with Kerlix (gauze) and tubigrips. 5/28/2024 at 9:24 P.M. - Eucerin External Lotion, apply to dry skin topically every day and evening shift related to pruritis. Legs are open wounds, weeping, no dry skin. 5/29/2024 at 5:23 A.M. - Upon entering the resident's room to administer medications, resident is found to have moderate tremors, pale, alert, but unable to follow commands. Vitals were assessed. Resident is warm to touch. Call placed to Impact and order received to send the resident to the ED. Staff notified the resident's family. 5/29/2024 at 10:12 A.M., hospital notified facility resident admitted with pneumonia, metabolic encephalopathy, and fluid overload. The ED note dated 5/29/2024 reported the resident admitted with mental status change. It also revealed the resident had extensive open, blistered stasis changes to both lower extremities. Overlying wraps in place. 5/29/2024 hospital records included: Active Hospital Problems: Diagnosis - cellulitis of lower extremity, delirium, ESRD, diabetes. Clinical Impression: metabolic encephalopathy, pneumonia to left lower lobe due to infectious organism, abnormal urinalysis and abnormal lower left lung on chest x-ray. Rocephin (antibiotic) has been given. Sepsis, early detection 5/29/2024. The resident's physical exam revealed she had wounds to bilateral lower extremities, scabs to upper arms from itching and erythema to groin. The resident admitted to inpatient care on 5/29/2024 and discharged to a care facility on 6/7/2024 with hospice services. The 6/7/2024 discharge Hospital Problem list included Cellulitis of lower extremity. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A facility In-Service form dated 4/4/2024 revealed nursing staff received education related to Any new skin concerns should be documented, picture taken, risk management completed by the nurse at the time of the impairment being reported and/or observed. A facility In-Service form dated 10/1/2024 revealed the facility began re-educating nursing staff regarding skin/wound assessment and intervention. On 9/30/2024 at 1:35 P.M., Staff A, RN (Registered Nurse), ADON (Assistant Director of Nursing) indicated Resident #1 complained of being itchy. Staff notified Impact and they ordered different creams. Staff A contacted Impact and informed them the resident's husband revealed she had a prescription for Hydroxyzine (for itching). Impact never ordered Hydroxyzine for the resident. The resident scratched her legs as far as she could reach, and nothing seemed to help. At 3:30 P.M. Staff A reported the resident sternly refused staff to touch her legs. She had an order for staff to do skin checks weekly and that order never stopped. The facility failed to provide skin evaluations after 4/11/2024, and the Progress Notes failed to include skin assessments including measurements. If staff found the resident had a new skin concern, they were to complete a Risk Management Evaluation, notify family and provider, and start weekly skin assessments until it's resolved. On 10/1/2024 at 10:30 A.M., Staff B, Nurse Practitioner indicated staff reported the resident was itchy, and she did not want to order Benadryl (antihistamine) tablets due to the [AGE] year old resident received dialysis. The resident had blisters on the lower extremities that opened up and she transferred to the ED. According the the resident's record available to Impact, it appeared the resident already had an order for Hydroxyzine. When Hydroxyzine is ordered, the order is good for 14 days. The facility Ulcers/Skin Breakdown policy revised 9/2017 included: Policy Statement: Physicians shall help prevent and manage pressure ulcers, consistent with established guidelines. Outcomes: 1. Incidence of new pressure ulcers will be minimized to the extent possible. 2. Healing of existing pressure ulcers will be optimized to the extent possible. 3. The facility will be able to show that failure of a pressure ulcer to heal was medically unavoidable. Procedure: Identify Risk Factors Identify Existing Pressure Ulcers Define Details of Pressure Ulcers (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Identify Contributing Factors Clarify Medical Factors Order Pertinent Interventions Identify Related Medical Interventions Limited Effectiveness of Nutritional Supplementation Recognition: 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility and medical instability. The facility Pressure Ulcers/Skin Breakdown - Clinical Protocol revised April, 2018 included: Assessment and Recognition: 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses. 3. The staff will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. 4. As needed, the physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. 5. As needed, the physician will help identify and define any complications related to pressure ulcers.