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	02/12/2026

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

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, resident interviews and policy review, the facility failed to provide resident call light access for alerting staff of needs or in the event of an emergency for 3 of 24 residents reviewed for call light access (Residents #42, #69, and #73). The facility reported a census of 87.Findings include: 1. Resident #73's Minimum Data Set (MDS) assessment dated [DATE] identified Brief Interview of Mental Status (BIMS) scored 14, indicating intact cognition. The MDS included diagnoses of heart failure, orthostatic hypotension, high blood pressure, and kidney failure. The Care Plan Focus initiated 1/24/26 identified Resident #73 had a risk for falls. The Interventions directed to encourage him to use the call light for assistance. On 2/9/26 at 2:44 PM Resident #73 relayed he came to the facility for therapy. He had low blood pressure and repeat falls. He reported the call light worked when he arrived, then it became unpredictable. It didn't work on Saturday 2/6/26 and he alerted staff who looked at it. He stated the light would come on in the room but, not on the board that alerted the staff. He added he didn't know if it worked like it is supposed to. On 2/9/26 at 2:46 PM Resident #73 agreed to test to call light and pushed the button, observed a small red light came on at the cord outlet. After 15 minutes without no one responding, the surveyor stepped out of the room to check the staff board. On 2/9/26 at 3:02 PM observed the call light board used to alert staff of resident calls; the board did not indicate Resident #73 pushed the call light. On 2/9/26 at 3:09 PM Resident #73 pushed the call light again, a red light went on and then off. Resident #73 relayed at times staff fiddled with the reset button to make the light work. On 2/9/25 at 3:45 PM Staff A, Certified Nursing Aide entered Resident #73's room, reported they didn't know his call light didn't work. Staff A pushed the call light button, the red light came on. Staff A left the room, came back in and confirmed the alert didn't show on the staff board. Staff A queried about the process when it didn't work, Staff A replied they would submit a work order. Staff A added all staff could submit a work order. Staff A summoned Staff C, Registered Nurse (RN), to the room On 2/9/25 at 3:50 PM RN, Staff C entered Resident #73's room and pushed the call light. Staff C left the room to view the staff board. Staff C came back, confirmed the call light did not work to alert staff on the board. Staff C reported they would submit a request to maintenance. Staff C gave Resident #73 a bell to shake to alert staff as needed. (continued on next page)

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

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/10/25 at 1:15 PM Resident #73 explained while in his room the Maintenance staff hadn't looked at the call light. Resident #73 pushed the button and reported the call light didn't work at all. The observation revealed no red light came on and confirmed it didn't show up on the staff alert call board. On 2/10/26 at 1:47 PM Staff B, CNA, explained several residents on other halls that have bells to ring due to call lights not functioning properly. They said no one told them Resident #73's call light didn't work and instead used a bell. Staff B confirmed Resident #73 preferred to keep his room door closed. On 2/10/26 at 2:05 PM Staff F, Maintenance Supervisor, reported he didn't know of any call lights not working. He explained the process used for concerns or repair needs. Staff F relayed the staff should put in a work order to alert maintenance as soon as they identify a problem. Staff F reported they had a tracking application of work orders on the phone and currently had no work orders. Staff F showed his phone that displayed 0 work orders. Staff F reported the facility just purchased the current call light system July of last year. They had replaced several cords under warranty that didn't' function. Staff F reported they expected the staff to alert maintenance and submit a work order for concerns. On 2/10/26 at 3:15 PM the Administrator relayed frustration with the new system and expected staff to first provide a bell to ring if the call light didn't function and submit a work order to maintenance. On 2/10/26 at 4:14 PM Staff D, CNA, explained the new call system function like a new one should. When a call light didn't work, the staff should give residents bells. They didn't know Resident #73 had a bell nor that his call light didn't work. On 2/10/26 at 4:16 PM Staff E, CNA, queried about the call light system and shared several residents on another hall have bells to ring due to ongoing issues with their call lights. They found sometimes the remedy is to hold the reset button longer, or unplugged it and plugged it back in to get it to work. 2. Resident #69's MDS assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of non-Alzheimer's dementia, repeated falls, unsteadiness on feet, weakness, abnormalities of gait and mobility. The Care Plan Focus initiated 10/7/24 indicated Resident #69 had a risk for falls related to limited mobility. The Interventions instructed to encourage them to use their call light for assistance. On 2/9/25 at 10:20 AM Resident #69's family shared Resident #69 stayed at the nursing facility for support by staff and memory concerns. Observed Resident #69 sitting in her chair with no call light within reach. On 2/10/26 at 9:25 AM witnessed Resident #69 sitting in a bedside chair next to the window, with the door open, and no call light within reach. The call light cord hung from wall, behind the bedside dresser, down to the floor, curled under the bed. On 2/10/26 1:59 PM observed Resident #69 sitting her room with their door open. They welcomed the surveyor in. The observation revealed no call light in reach, the cord hung from wall behind bedside table on the floor under the bed. On 2/11/26 at 9:52 AM saw Resident #69 in their room with the door closed. Resident #69 welcomed a visit and relayed sometimes they liked to keep the door closed. Resident #69 queried if they needed staff assistance how would get help in an emergency. Resident #69 responded they could get up and (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thought could press a button. As they said that, they reached the reset button on the wall that did not activate the call light. Resident #69 relayed they didn't know where the call light cord was. Observed the call light cord hanging alongside the wall behind the bedside table, curled on the floor under the bed. Resident #69 relayed they wanted the door kept closed that day, resulting in them not in view of staff. On 2/11/26 at 10:15 AM the Director of Nurses, (DON) reported they expected the call light to be accessible to all residents. The DON entered Resident #69's room and confirmed they didn't have their call light available. She added she would ensure to provide staff education. The Policy titled, Answering the Call Light, revised March 2021 documented, upon admission and periodically as needed explain and demonstrate use of the call light to the resident. Be sure the call light is plugged in and functioning at all times. Report all defective call lights to the nurse supervisor promptly, and when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 3. Resident #42 MDS dated [DATE] identified a staff assessment for mental status indicating she had severely impaired cognitive skills for daily decision making. Resident #42 needed supervision or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.) for eating. The MDS listed Resident #42 dependent (helper does ALL of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity.) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, rolling left to right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair to bed/bed to chair transfer and toilet transfers. The MDS included diagnoses of a stroke, hemiplegia (a severe form of paralysis affecting one side of the body), post-traumatic stress disorder (PTSD), and depression. The Care Plan Focus initiated 7/11/23 identified Resident #42 as a risk for falls related to a history of a stroke with hemiplegia affecting her right dominant side. The Interventions directed staff to encourage Resident #42 to use her call light for assistance. On 2/9/26 at 10:30 AM, observed Resident #42 sitting up in bed watching TV. Her call light cord wrapped around the middle of the headboard of the bed, not within reach of Resident #42. On 2/11/26 at 11:01 AM, observed Resident #42 lying in bed in a raised position. The call light laid coiled up on the floor behind the left side of the headboard of the bed, not within reach of Resident #42. On 2/11/26 at 11:03 AM, Staff G, Certified Medication Aide (CMA), verbalized the residents should have call lights placed within their reach. On 2/11/26 at 11:06 AM, Staff H, CMA, verbalized residents should have call lights within their reach. On 2/11/26 at 11:08 AM, Staff G and Staff H acknowledged Resident #42 didn't have her call light within reach. On 2/11/26 at 1:36 PM, the Director of Nursing (DON) verbalized all of the residents must have their call lights within reach of them at all times.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, clinical record review, policy review, family, and staff interviews, the facility failed to maintain a homelike environment free of odors. The facility identified a census of 87 residents.Findings include:On 2/9/26 at 10:41 AM smelled a slight urine odor outside Resident #53's room door. The nurse entered Resident #53's room to administer medications and returned to the medication cart parked outside in the hallway just up from Resident #53's room. Another staff member stood at a treatment cart in hallway approximately 3 doors down from Resident #53's room door talking to another resident.On 2/9/26 at 10:46 AM observed Resident #53 lying in bed. Upon entrance to the room noted a strong, stale urine type odor throughout the room. Resident #53 sat up in bed and stated they didn't smell an odor in the room. She explained when she tried to stand up urine just runs out of her. Resident #53 admitted if she had wet linens or brief, she would throw them on the floor. She stated she really didn't use her call light and the staff eventually come clean it up. She just didn't have control of her urine. Further observation revealed a small blue wet blanket to the right side of the bed lying on the floor. The Care Plan Focus related to activities of daily living (ADLs) initiated 8/27/25 included an Intervention initiated 9/16/25 that described Resident #53 as non-compliant with toileting, using the call light, and she would throw soiled briefs on the floor. The Care Plan lacked further direction for the staff on what to do for Resident #53 or how to address the odor in her room. On 2/10/26 at 2:33 PM approximately 3 feet outside Resident #53's room door, smelled a stale, musty urine type odor. At the time several second shift staff and the maintenance man stood in the hallway outside of the doorway. Interview on 2/11/26 at 7:59 AM Staff P, Housekeeping Aide, reported generally the facility had a housekeeper for each hallway. They check first to see if there are any hotspots that need addressed. Each resident's room is cleaned daily Monday through Friday. On the weekend the facility schedules 2 housekeepers. One housekeeper has to clean two hallways each; (100 and 200 hallways) (300 and 400 hallways). Staff P explained on the weekends, one day they just do a wipe down in the room and empty garbage. Then the other day, they do a full cleaning of the room, including mopping. They only mop resident's rooms once on the weekends. Staff P stated they didn't have any rooms that require more cleaning. If the odor comes from a commode the Certified Nursing Assistants (CNA's) clean that, housekeeping didn't. The aides need to clean the mattress if the resident had incontinence through the mattress. Sometimes the aides come get their disinfectant spray and take care of it. Housekeeping cleaned the mattresses after a resident's discharge. They didn't clean the mattresses on their baths days unless the CNA's asked them too. No one has asked to special clean any mattresses for a long time. On 2/11/26 at 8:07 AM observed Staff M, CNA, and Staff Q, CNA, in the hallway outside of Resident #53's room passing breakfast trays to that area's rooms. Noted a stale, musty urine type odor waft approximately 2 feet outside of the room. At 8:08 AM Staff N, Assistant Director of Nursing (ADON), took a breakfast tray into Resident #53's roommate and assisted her roommate to sit up for breakfast. As Staff N exited the room a prominent urine type odor came into the hallway. On 2/11/26 at 8:11 AM the observation revealed no environmental aides on the hallways cleaning rooms at the time. During an observation on 2/11/26 at 8:13 AM Resident #53 sat upright in bed finishing her breakfast. At 8:14 AM watched Staff M and Staff N enter Resident #53's room to work with Resident #53's roommate. They exited the room at 8:16 AM, the room continued to have a lingering stale urine odor. On 2/11/26 at 8:22 AM witnessed 1 housekeeper down the D hallway and 1 housekeeper cleaning in the public areas. No other housekeepers observed cleaning in the A, B, C hallways at that time. During an interview on 2/11/26 at 9:09 AM Staff M explained Resident #53 has an incontinence problem and she starts to go the minute she stands up. She added that is why the floor gets wet and sticky in the room. When queried about room odor, Staff M stated, yes ma'am, lots of urine odor which she thinks is starting to seep into the floor. They have talked to management about the situation and the smell. Management didn't really know anything about the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	situation until recently. Staff M reported the wet, sticky floors to Staff N about a month ago. They clean the commode as part of every few hour rounds, but it is hard. They wash out the commode pan with soap and water, but they don't have any products to do a deep clean of the commode pan. In addition, Staff Q verbalized an constant odor to Resident #53's room. On 2/11/26 at 9:31 AM smelled a stale, musty, urine type odor approximately 2-foot outside of Resident #53's room into the hallway. Witnessed the Director of Nursing (DON) walked by Resident #53's doorway to another resident's room. Interview completed on 2/11/26 at 9:35 AM Resident #53's Family Member reported having a conversation with the charge nurse last Saturday (2/7/26). The Family Member came to visit Resident #53 and reported being devastated she had piss stains all over the sheets, with a urine filled soaker pad on the floor. The Family Member voiced talking to the facility before about the situation and it got better for some time, but they noted it getting worse again. Observation on 2/11/26 at 9:54 AM revealed a housekeeping cart on the 300, C-hallway starting to clean rooms. Staff R, Housekeeping Supervisor reported on the weekend they staff 2 housekeepers who are responsible for cleaning two hallways each. The weekend housekeepers did room cleaning one day on one hallway and then the next day clean resident rooms on the other wing. On the weekend day, the room didn't get a full cleaning, the housekeepers sweep the floor, empty the garbage and clean the bathrooms if needed. They cleaned the resident's rooms daily Monday through Friday. The Housekeeping Supervisor reported one other random resident, not included in the sample that required more room cleaning. They didn't identify Resident #53's room as needing additional cleaning. During an interview on 2/11/26 at 10:22 AM the Housekeeper Supervisor explained they cleaned the resident rooms daily and as needed. When they attempt to clean Resident #53's room, she would refuse as she didn't like the staff to touch her things. They added they would always have the smell there at that rate. She reported she couldn't be responsible for what happened when she left for the day. On 2/11/26 at 10:27 AM the DON reported Resident #53's room odor smelled much worse when the resident resided on a different hallway. The Administrator voiced they were in Resident #53's room all the time and running the carpet cleaner daily. They moved Resident #53 to a room with laminated flooring to make it easier to maintain. Staff R reiterated she didn't know when someone cleaned Resident #53's mattress. They clean the mattresses when the resident takes a shower or discharges. Staff M voiced they would report to the hallway housekeeper when Resident #53's needed cleaning due to urine on the floors. Staff M voiced the housekeeper usually just did the routine daily room cleaning and didn't go right down to the room to address it right away. Staff M then started to backtrack her statement as the Housekeeping Supervisor gave her a look. Staff M repeated 3 times, I'm sorry. The DON voiced to Staff M it was okay. On 2/11/26 at 10:35 AM the Administrator reported they had several conversations about Resident #53's room and maybe it was time that they needed to revisit it again. On 2/11/26 at 10:36 AM the Housekeeping Supervisor stated the aides need to get Resident #53 out of the room so they can do a deep clean of the room. The Housekeeping Supervisor identified the commode bucket had a lot of urine odor and needed to be changed out of the room. On 2/11/26 at 10:40 AM the Administrator voiced they may have to get Resident #53 a new mattress. On 2/11/26 at 11:16 AM the Housekeeping Supervisor reported they deep cleaned the room and described the smell of the urine in the room as even worse now. Observation at this time revealed the middle 1/3 of the mattress with a strong musty urine smell and the floor with a strong, musty urine smell. The floor exhibited a tacky texture. The Housekeeping Staff's shoes stuck to the floor as they walked in the room. Staff S, Housekeeping Aide, reported the room had a stuck down slightly blackened stain that ran from where the commode sat, then down the floor underneath the closet cabinet (approximately 4 feet) that she mopped up. The Housekeeping Supervisor reported she would try to go over the floor again, but each time they tried to clean the urine smell it just kept getting worse and worse. A 2/11/26 review of Resident #53's Shower Skin Cheek Sheet provided by the DON revealed the resident had refused her bath in January 2026 on the 14, 21, 24.On 2/11/26 at 1:21 PM Staff X, CNA, reported her room had a strong odor to it many times. They try to empty her bedside commode (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regularly. They dump and rinse the commode pan, but they don't really clean the commode pan as they usually use a garbage bag liner in it. Staff X voiced she thought the odor came from needing her bed changed or from urine contacting the floor. When they mop the floor, the odor is better. A review of the Housekeeping Deep Cleaning a Room Record for January and February 2026 lacked documentation of more than daily cleaning for resident rooms. The Housekeeping Deep Cleaning a Room Record dated 2/6/26 Staff P documented crossed out squiggles for rooms 301-316 and included hand written at the top of the Record, they swept the rooms, mopped and emptied the garbage. The Record dated 2/7/26 documented rooms 301-316 had been cleaned daily. The Record dated 2/8/26 contained a large X through the whole document by Staff T, Housekeeping Aide. During an interview on 1/12/26 at 11:35 AM the Administrator reported they tried to provide a clean homelike environment. He agreed the average person wouldn't like their room to have a urine odor present.The Homelike Environment Policy, revised 2021, provided by the facility directed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:a. clean, sanitary and orderly environment;b. clean bed and bath linens that are in good condition;c. pleasant, neutral scents. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include institutional odors.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User Manual, and staff interviews, the facility failed complete the Minimum Data Set (MDS) Assessment within 14 days of admission for 1 of 2 resident reviewed for new admission (Resident #39). The facility identified a census of 87 residents.Findings include:An Electronic Medical Record (EMR) Census documented Resident #39 admitted to the facility on [DATE].Resident #39's MDS 3.0 Summary Page showed the admission MDS signed off as completed late on 9/5/25. During an interview on 2/12/26 at 11:50 AM Staff L, MDS Coordinator, reported the facility completed Resident #39's MDS late. They look at the MDS list and spend time everyday working on them, looking to see where they are at. Staff L stated she has a calendar made up that she used to track when the MDS are due. Staff L voiced they have one week to get the MDS done and she utilized a Paper Document Titled Section GG Collection Dates which specified the day of admission counted as day 1 of the residents stay. Staff L reiterated they utilize the RAI manual for the MDS. The LTC RAI 3.0 User Manual, directed the admission MDS completion date is required no later than day 14 of the resident's stay.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User Manual, and staff interviews, the facility failed encode and transmit Minimum Data Set (MDS) documents to the CMS system in the appropriate time frames for 3 of 4 records reviewed for MDS timing requirements (Residents #36, #39 and #61). The facility identified a census of 87 residents.Findings include:1. Resident #36's Electronic Healthcare Record (EMR) Census documented a discharge date of 8/7/25. Resident #36's MDS Discharge Return Anticipated Assessment documented a discharge date in A2000 of 8/7/25. Section Z0400 related to the signature of persons completing the assessment or entry/death reporting reflected a completion date of 8/24/25.The MDS 3.0 Summary Page documented a MDS Discharge Return Anticipated Assessment completed late on 8/24/25, 24 days after their discharge.During an interview on 2/12/26 at 11:50 AM Staff L, MDS Coordinator, reported they look at the MDS list and spend time everyday working on the MDS schedule. Staff J, MDS Coordinator, stated she made up a MDS calendar that she used to track the MDS due dates, evaluation dates and Care Plan dates. Staff L voiced she tried to batch MDS documents to the (CMS) database every week and thought they had one week to transmit the records in. Staff L reported they follow the RAI for completing the MDS. The RAI 3.0 User Manual directed Discharge Assessments must be completed within 14 days of the discharge date and transmitted 14 days from the completion of the discharge assessment date to the CMS data base.2. Resident #39 EMR Census documented an admission date of 8/12/25 and a discharge date of 8/18/25. A Discharge Return Not Anticipated Assessment documented a discharge date of 8/18/25 in A1600. Section Z0500 related to the signature of the Registered Nurse, RN, reflected a completion date of 9/5/25.Resident #39's MDS 3.0 Summary Page documented the Discharge Return Not Anticipated Assessment as completed late on 9/5/25. 3. Resident #61's EMR Census documented a discharge date of 9/30/25.A MDS Tracking Page documented a 9/16/25 Entry Tracking Form and a 9/22/25 admission MDS Assessment. The MDS Tracking page lacked documentation of the completion of a Discharge Assessment. A review completed on 2/12/25 of the MDS Tracking Page documented a 9/30/25 Discharge Return Not Anticipated Assessment completed and waiting for transmittion to the CMS data base.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User Manual, and staff interviews, the facility failed to accurately code the Preadmission Screening and Resident Review (PASRR, an assessment for serious mental illness or intellectual or developmental disability for appropriate services) on the Minimum Data Set (MDS) assessment for 2 of 2 residents sampled (Resident #6 and #10). The facility identified a census of 87 residents.Findings include: 1. Resident #6's Notice of PASRR Level 1 Screen Outcome dated 10/2/25 documented a Determination of Level 1 Positive, No Status Change. The PASRR Outcome Explanation documented Resident #6 had evidence of a serious mental illness. The previous PASRR Summary of Findings remains valid for your stay. The Explanation further detailed the facility should mark yes for question A1500 on the MDS, Is the resident currently considered by the state level II PASRR process to have serious mental illness. Also, the PASRR condition(s) should be checked in question A1510, Level II PASRR Conditions. Resident #6's MDS assessment dated [DATE] documented in Section A1500 Resident #6 didn't have a serious mental illness and/or intellectual disability related condition. Section A1510 was blank. The MDS listed diagnoses of anxiety, depression, and post-traumatic stress disorder. The MDS reflected Resident #6 utilized antipsychotic, antianxiety and antidepressant medications during the lookback period. Resident #6's Notice of PASRR Level II Outcome dated 11/22/24 documented Resident #6 required specialized services for behavioral health. A review conducted on 2/11/26 of the Electronic Medical Record Profile Page documented Resident #6 as a level 1 under the PASRR Level. Interview completed on 2/11/26 12:36 PM Staff K, Social Service Coordinator explained they list the resident PASRR level of the Profile Page. Staff K pulled up Resident #6 Profile page and listed her as a PASRR level 1. During an interview on 2/11/26 at 12:42 PM Staff L, MDS Coordinator, reported Resident #6 is a level 1 for PASRR. Staff L explained when coding the PASRR status she looked at the resident's profile page and sometimes looked at the resident's PASRR in the documents area (of the medical record). After reviewing the 10/2/25 PASRR she stated she didn't know Resident #6 had a level II PASRR. She verified the annual MDS as not coded correctly. Staff L explained they follow the RAI manual to code the MDS assessments. The CMS LTC RAI 3.0 User's Manual, October 2025, Version 1.20.1, Page 1-4 documented the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require the assessment accurately reflects the resident's status. 2. Resident #10's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #10 is not a level II PASRR. (continued on next page)

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	02/12/2026

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10's PASRR dated 12/16/25 documented a Positive level I, no status change (positive Level II on file, a new Level II is generally not required unless they experience a significant change in condition). Resident #10's PASRR dated 3/26/24 documented a Level II approved with specialized services. On 2/12/26 at 11:02 AM Staff J, MDS Coordinator, confirmed the Annual MDS as coded wrong as Resident #10 is a level II PASRR.

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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, facility records, policy review, and staff interviews, the facility failed to utilize infection control standards to prevent cross contamination when they placed gauze that dropped on a bed pad directly on a wound for 1 of 2 residents reviewed (Resident #65). The facility reported a census of 87 residents. Findings include:Resident #65's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS listed Resident #65 as frequently incontinent of urine and bowel during the lookback period. The MDS listed active diagnoses of wound infection, diabetes mellitus and chronic obstructive pulmonary disease (COPD - an ongoing lung condition caused by damage to the lungs). The MDS identified Resident #65 required surgical wound care and application of a nonsurgical dressing. A Progress Note dated 2/6/25 at 6:35 PM documented the surgical incision site measured 7.03 centimeters (cm) in length and 9.97 cm in width with an area of 9.65 cm. The wound had 10% exudate (a fluid rich in protein, cells, and solid materials that leaks from blood vessels into nearby tissues, usually due to inflammation or injury). The note described the exudate type as serosanguineous: a mixture of serous and sanguineous fluid, typically pale, red, and watery.A Physician Order dated 2/7/26 instructed staff to change spinal dressing daily and as needed. The order directed to apply dry gauze to incision site and tape, don't cleanse with anything or put any creams, ointments, etc. on incision site. The Care Plan Report initiated on 9/30/25 identified Resident #65 had a surgical incision/wound to the lower back. The Care Plan Report instructed staff to weekly evaluate wound healing and provide incision care as ordered by the physician. The Care Plan Report revised on 10/30/25 identified Resident #65 had impaired skin due to a surgical incision. The Care Plan instructed staff to use Enhanced Barrier Precautions (an infection control strategy in nursing homes requiring staff to use gowns and gloves during high-contact resident care-such as dressing, bathing, or transferring-to prevent the spread of multidrug-resistant organisms MDROs). On 2/11/26 at 1:21 PM, observed Resident #65 sitting up in bed. Resident #65 used the bed control to lower the head of her bed. Resident #65 removed the top sheet and rolled onto her right side. Resident #65 had an incontinent brief and was positioned on a linen bed pad on the fitted sheet of the bed. Staff I, Licensed Practical Nurse (LPN), sanitized her hands, donned (applied) a gown and gloves. Staff I, raised Resident #65's shirt and lowered the top of the incontinent brief. Staff I removed the dressing on her spine and threw it away. Staff I, removed her gloves, sanitized her hands and donned new gloves. Staff I opened gauze and folded the gauze in half, staggering 3 gauze pads. Staff I attached 2 sections of the staggered gauze to the tape. The third folded gauze fell onto the surface of the bed pad. Staff I picked up the folded gauze off the incontinent bed pad and placed it on the tape. Staff I placed the gauze and tape on the spinal wound of Resident #65's lower back.On 2/11/26 at 1:30 PM, Staff I, LPN acknowledged a gauze pad fell on the bed pad and they placed directly on the wound. Staff I verbalized they shouldn't have used that gauze. The DON verbalized she didn't see the gauze drop onto the bed pad, but if it did, they shouldn't have used the gauze.On 2/12/26 at 9:45, Staff G, Certified Medication Aide (CMA), verbalized they changed resident bedding when a resident received a shower/bath. Staff G didn't know when they changed Resident #65's bedding.Resident #65 bath records revealed the following:1/26/26 bath completed1/29/26 bath not completed - Resident on leave of absence/ at appointment2/2/26 resident not available2/5/26 resident refused2/9/26 not applicableThe personnel file for Staff I, LPN reflected a hire date of 12/12/23. The Job Description signed by Staff I on 12/12/23 included essential functions of:Follow established standards of nursing practices and implement facility policies and procedures. Administer and document direct resident care, medications, external nutrition, treatments per physicians' orders and accurately record all care provided. The Orientation Checklist: Licensed Nurses documented wound care had been reviewed on 12/18/23 signed by Staff I on 12/20/23. The personnel file documented Staff I successfully (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed all requirements and received a Wound Care Certification on 7/17/25.The Dressings, Dry/Clean policy revised September 2013 directed staff to: Position resident and adjust clothing to provide access to the affected area.Wash and dry hand thoroughly.Put on clean gloves. Loosen tape and remove soiled dressing.Pull glove over dressing and discard into plastic or biohazard bag.Wash and dry your hands thoroughly. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface.Label tape or dressing with date, time and initials. Place on clean field.Using clean technique, open other produces (i.e. prescribed dressing; dry, clean gauze).The policy failed to direct staff of what to do if gauze/dressing comes into contact with a contaminated surface.

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility records, record review, policy review, resident and staff interviews the facility failed to follow their smoking policies to ensure resident safety for 1 of 1 resident reviewed (Resident #70). The facility failed to complete a smoking assessment or safety assessment to ensure a resident could safely smoke alone in the designated smoking area off the facility's property. In addition, the facility failed to ensure the facility grounds remained smoke free as declared by the staff with 50 cigarette butts on the facility's ground near the area of a resident observed smoking. The facility reported a census of 87 residents.Findings include:Resident #70's Minimum Data Set (MDS) assessment dated [DATE], documented an admission date of 12/20/25. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #70 used a walker and a wheelchair during the 7-day lookback period. The MDS listed Resident #70 as independent to wheel himself in a manual wheelchair. The MDS documented Resident #70 as a current tobacco user. The MDS documented active diagnoses of amputation, atrial fibrillation, heart failure, and peripheral vascular disease (PVD).Review of the facility provided Smoking Policy - Residents revised July 2017 reflected the following: Upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences.The resident will be evaluated on admission to determine if he or she is a safe smoker or non-smoker. If a smoker, the evaluation will include: ability to smoke safely with or without supervision.The staff shall consult with the attending physician and the DON to determine if safety restrictions need to be placed on a residents smoking privileges based on the Safe Smoking Evaluation.The resident's ability to smoke will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. Resident #70's Safe Smoking Evaluation completed on 2/9/26 at 10:23 AM documented the facility was a smoke free facility. The Safe Smoking Evaluation documented the following: Ability to hold cigarette safelyAbility to maintain control of cigarette if physically distractedAbility to light his/her cigarette safelyDemonstrate appropriate use of an ashtrayDemonstrate ability to let go of cigarette and then retrieve it appropriatelyDemonstrate ability to appropriately extinguish cigaretteThe Safe Smoking Evaluation documented the resident had not demonstrated non-compliance with the smoking policy requirements. The Safe Smoking Evaluation identified Resident #70 as an independent smoker with no adaptive equipment required. The Safe Smoking Evaluation lacked evaluation of the resident's ability to walk, wheel, or propel oneself off property to smoke if a resident chose to exit the facility without going out with family. The Safe Smoking Evaluation lacked evaluation of the resident's ability to maneuver outside in inclement weather including rain, snow or ice. Resident #70's clinical record lacked a smoking evaluation prior to 2/9/26.The Service Agreement effective 12/23/24 for the facility related snow removal, deicing, and lawn maintenance services. Snow removal and deicing services directed the following service requirements related to snow:Plow level 2: snow removal for 2.1-4 inches accumulationPlow level 3: snow removal for 4.1-6 inches accumulationShovel walks level 2: snow removal for 2.1 -4 inches of accumulationShovel walks level 3: snow removal for 4.1 - 6 inches of accumulationDeicing Services included deicing lot and sidewalks.The Care Plan Focus initiated 2/9/26 identified Resident #70 as non-compliant with the facility's smoking policy and didn't leave the property to smoke. The Interventions direct the staff to:Conduct Safe Smoking Evaluation at admission and as neededEducate resident/responsible party on the facility's tobacco/smoking policyStaff will educate resident on the facility's smoking policy, including where and when smoking is permittedStaff will redirect Resident #70 to appropriate locations when non-compliance is observedStaff will remind Resident #70 in a calm and respectful manner, that smoking is only allowed off facility property.The Care Plan Report lacked direction of where to keep smoking supplies, such as cigarettes and lighter. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition, the Care Plan Report lacked identifying where facility property ended and where it would be permissible to smoke. The Encounter Note dated 1/8/26 at 12:00 AM documented Resident #70 as a daily smoker who continued to smoke.The SPN - Skilled Evaluation dated 1/15/26 at 2:32 PM indicated Resident #70 had a chronic cough related to smoking.Review of the Release of Responsibility for Leave of Absence form for Resident #70 revealed he didn't sign out of the facility on the morning of 2/9/26. On 2/9/26 at 9:30 AM, observed Resident #70 sitting in his wheelchair smoking on the sidewalk on the north sidewalk between a bench and the north side of the parking lot. On 2/9/26 at 9:45 AM, the Administrator declared the facility as a smoke-free facility. They listed no residents as current smokers. The Administrator verbalized if a resident wanted to smoke, they would need to do so off property when they went out with family.On 2/9/26 at 2:11 PM, observed Resident #70 seated in his wheelchair outside the Director of Nursing's (DON) office. The DON identified Resident #70 as a smoker. On 2/9/26 at 2:15 PM observed the area where Resident #70 smoked revealed more than 50 cigarette butts lying on the ground around a bench, under a mature evergreen tree, and on the north side of the facility parking lot. The facility didn't have a receptacle to place cigarette butts in. On 2/10/26 at 7:47 AM, observed Staff O, Maintenance, outside on the facility sidewalk. He reported he picked up the cigarette butts. Staff O verbalized he saw cigarette butts on the ground after winter when the weather warmed up. On 2/10/26 at 8:30 AM, the Administrator denied knowing Resident #70 currently smoked. The Administrator added Resident #70 didn't smell like smoke. The Administrator reported residents needed to sign out of the facility if they leave when they went outside to smoke. The Administrator acknowledged the facility had a lot of cigarette butts on the ground where they observed Resident #70 smoking on facility property. The Administrator acknowledged Resident #70 didn't sign out of the facility on the morning of 2/9/26.On 2/10/26 at 1:07 PM Resident #70 verbalized he smoked. Resident #70 confirmed he smoked on the sidewalk between the bench and the parking lot on the morning of 2/9/26. Resident #70 reported someone chewed him out for it already. Resident #70 explained they told him he had to go out by the road to smoke. On 2/12/26 at 10:47 AM, Staff W, Rehab Director/Certified Occupational Therapy Assistant (COTA), verbalized she knew Resident #70. Staff W reported the smoking area as off property. Staff W explained therapy hadn't assessed Resident #70 abilities to transfer himself safely off the facility property to smoke in good or inclement weather such as rain, snow or ice. On 2/12/26 at 10:49 AM, Staff U, Doctor of Physical Therapy (PT), verbalized she knew Resident #70. Staff U acknowledged Resident #70 currently smoked. Staff U reported she didn't have any idea the location of the designated smoking area. Staff U explained she observed people on the sidewalk by the street smoking. Staff U reported PT didn't assess for wheelchair mobility. On 2/12/26 at 10:53 AM, Staff V, Occupational Therapist (OT), verbalized she knew Resident #70 currently smoked. Staff V reported she saw people smoking on the sidewalk by the bench and parking lot in the afternoons when she leaves the facility. Staff V reported she didn't know if anyone assessed Resident #70 for safety getting to an area to smoke in good weather or inclement weather. On 2/12/26 at 10:57 AM, Staff L, MDS Coordinator acknowledged she completed the MDS dated [DATE] for Resident #70 which identified him as a current smoker. Staff L verbalized any of the nurse managers could complete the Safe Smoking Evaluation. Staff L reported someone should have completed the Safe Smoking Evaluation sooner. Staff L verbalized residents who choose to smoke had to do so off property on the sidewalk by the road. Staff L verbalized no one assessed Resident #70 safety in getting himself to a smoking area off the property in inclement weather such as rain, snow or ice. On 2/12/26 at 11:07 AM, the DON acknowledged the Safe Smoking Evaluation lacked an evaluation of a resident's abilities to safely maneuver oneself off the property to smoke.