STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165290	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Crest Living Center	34 Northcrest Drive Council Bluffs, IA 51503

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49628 Based on observations, clinical record review, facility document review and staff interviews, the facility failed to ensure implemented interventions to reduce hazards and protect residents were followed for 3 of 3 residents (#1, #2 #3) reviewed. The facility reported a census of 54 residents. Findings include: 1. The Minimum Data Set (MDS) assessment of Resident #1 dated 7/5/24 reflected the Brief Interview for Mental Status (BIMS) score of 9/15, indicating moderate cognitive impairment. The resident required extensive assistance for bed mobility/transfers, dressing, hygiene, and toileting. The resident used a walker and wheelchair. Resident #1 hand an indwelling catheter and had occasional bowel incontinence. Resident #1's Care Plan revealed an intervention dated 7/1/24 directing staff the resident transferred with assistance of 2 staff with a gait belt and walker. Fall interventions for staff to use dated 7/1/24 the resident required the call light within reach, use the call light and prompt response for all requests for assistance, check on resident frequently throughout the shift, and call light education provided was added on 7/30/24. On 8/2/24 at 2:11 PM Staff D, Certified Nursing Assistant, stated she had transferred the resident to the bedside commode for toileting. When Resident #1 indicated she was finished, Staff D said she transferred the resident back to bed, covered her up, and attached her call light to her garment. The staff stated the resident asked her to go talk to the nurse and request pain medication. Staff D stated she did as the resident requested and returned to her room in less than 5 minutes with the nurse's response, when she saw the resident standing up at the edge of her bed, lose her balance, and fall to the floor. The staff stated the resident still had her call light attached to her. The nurse completed an assessment on the floor, and staff assisted to get the resident up. Staff D stated Resident #1 refused to go to the hospital. On 8/5/24 at 1:40 PM a family member reported the resident had sustained a femur fracture, and had surgery. The family member stated the family chose to move the resident to another facility. Review of a facility provided document titled, Past Calls, for room [ROOM NUMBER] dates 7/1/24 - 7/31/24 revealed 41 instances where responses were longer than 15 minutes. The document revealed at the date of the fall Resident #1 did not have any call lights greater than 14 minutes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/24 at 6:18 AM the resident was found on the floor. On 8/2/24 at 12:00 PM observed Resident #3 sleeping in a low bed with a low air loss mattress, no bolster and fall mat beside the bed. The television was on. On 8/2/24 at 12:15 PM observed Staff B and Staff C prepare to complete personal cares for Resident #3. Staff B removed the fall mat and there was no removal of bolsters. The television was on when the staff woke up the resident. On 8/2/24 at 3:35 PM the Director of Nursing (DON), stated if a resident has frequent falls the DON and the nurse on duty will review the fall and possibly develop an immediate intervention. If the fall is unwitnessed the immediate intervention will be to complete neuro checks. The DON stated the Infection Control/Wounds Nurse will complete the fall review and will coordinate with the DON and the MDS Coordinator. The DON stated once the review is completed, the MDS Coordinator will update the Care Plan with the necessary interventions. The DON stated the Care Plans required revisions and updates to reflect needs of the residents. The staff indicated if someone is standby assistance staff should walk beside the resident. If the resident is identified as 1 assist a gait belt should be on the person. Review of facility provided document 2567 Education Compliance dated 7-23-24 provided the process of what staff were to do if a fall were to occur. The facility document, Fall Protocol dated 3/4/20, revealed the process for management of the resident post fall. The document included physical assessment with initiation of neuro checks, notification of the primary care physician, responsible party. A Fall Assessment document is completed in the Risk Management tab of the electronic medical record. The facility document, Call Light Protocol no date, revealed all staff members who see or hear an activated call light are responsible for responding. The document indicated the first step of the process for responding to the call light is to turn the signal off in the resident ' s room. The facility did not have a protocol for transfers.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on resident interview, family interview, clinical record review, facility document review and staff interviews, the facility failed to provide nursing staff to meet the needs of the residents by not responding to call lights in a timely manner for 2 of 3 residents (Resident #1 and Resident #2) reviewed. The facility reported a census of 54. Findings include: 1. The Minimum Data Set (MDS) assessment of Resident #1 dated 7/5/24 reflected the Brief Interview for Mental Status (BIMS) score of 9/15, indicating moderate cognitive impairment. The resident required extensive assistance for bed mobility/transfers, dressing, hygiene, and toileting. The resident used a walker and wheelchair. Resident #1 had an indwelling catheter and had occasional bowel incontinence. On 8/5/24 at 1:40 PM a family member indicated the resident would have call lights that could range from 25-35 minutes in length before being answered. The family member stated a staff member said on one occurrence it had taken a while to answer the call light due to several other falls that had just occurred. The family member stated the worst time for call lights was during meals as there were no staff left on the hall to answer the call lights. The family member stated it did not matter which meal. The family member stated the resident had been transferred to a different facility. Review of a facility provided document titled, Past Calls, for room [ROOM NUMBER] (Resident #1 room) dates 7/1/24 - 7/31/24 revealed 41 instances where responses were longer than 15 minutes. 2. The MDS assessment of Resident #2 dated 7/16/24 reflected a BIMS score of 12/15, indicating moderate cognitive impairment. The MDS indicated the resident was dependent for dressing, toileting hygiene, and footwear. Resident #2 required partial moderate assistance for sit to stands, toilet transfers, chair to bed to chair transfers, and walking 10 '. The resident utilized a walker and wheelchair. On 8/2/24 at 3:00 PM the resident stated it sometimes takes staff a while to answer the call light, and therefore will take herself to the bathroom. On 8/2/24 Staff A, Certified Nursing Assistant, stated call lights should be answered within 15 minutes if at all possible. The staff carry devices that alert them to the call lights. Review of a facility provided document titled, Past Calls, for room [ROOM NUMBER] (Resident #2 room) dates 7/1/24-7/31/24 revealed 18 instances where responses were longer than 15 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/24 at 5:05 PM the Director of Nursing (DON) stated on 7/4/24 Resident #1 had a few call light reports for over 15 minutes but the staff were responding to the resident's needs as a family member was present and had lots of questions. The DON stated the staff may have forgotten to turn the call light off when entering the room. The DON revealed that it is her expectation overall that call lights be answered in 15 minutes or less. The DON stated there may be times that the expectation may not be met such as during meals. The staff stated any call light over 15 minutes will be sent to her for review. The facility document titled Call Light Protocol, no date, revealed all staff members who see or hear an activated call light are responsible for responding. The document indicated the first step of the process for responding to the call light is to turn the signal off in the resident's room.

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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. 49628 Based on observation, clinical record review, staff interviews, and facility policy review, the facility staff failed to maintain infection control practices by failed to wash hands during personal care for 1 of 2 residents reviewed (Resident #3). The facility reported a census of 54 residents. Findings include: The Minimum Data Set (MDS) assessment of Resident #3 dated 6/11/24 reflected the Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The resident was dependent on staff for toileting hygiene and clothing management. The resident was always incontinent of bladder and bowel. The Care Plan provided staff with interventions for toileting, bed mobility, hygiene and transfers. Resident #3 required 1-2 staff for toileting, bed mobility, and hygiene. Transfers were completed with the use of 2 staff and a full body lift (Hoyer Lift). Continuous observation on 8/2/24 at 12:12 PM revealed Staff B, Certified Nursing Assistant (CNA), and Staff C, CNA, complete personal hygiene and transfer with Resident #3. Upon entry into Resident #3's bedroom Staff B and Staff C completed hand washing in the sink and proceeded to gather supplies for personal/peri hygiene. The staff determined who was managing the clean and the dirty aspects of care. The clean supplies (gloves, wipes) were placed in a clean bag for placement on the bed. A separate bag was obtained for the dirty. Staff B removed the fall mat and re-washed her hands. Gloves were donned by Staff B and Staff C. Staff B provided Staff C with wipes and gloves as needed. Staff C doffed the brief and began front peri care. Gloves were changed numerous times throughout the peri care process by Staff B. With each glove change completed by Staff C there was no hand hygiene completed. After completing the final step of completing peri cares, the dirty bag was closed, tied and placed to the side. Staff B and Staff C removed gloves and completed hand washing. The resident's blanket fell to the floor. Staff B donned gloves, picked up the blanket, placed it in a bag, tied shut and removed her gloves. Staff B and Staff C completed a dependent lift with the use of Hoyer Lift. Staff B managed the mechanics of the lift, while Staff C spotted Resident #3 and positioned in the tilt in space wheelchair. Staff B washed her hands and donned gloves, and Staff C donned gloves without hand hygiene. Staff proceeded to remove the resident's top and perform hygiene. Staff B provided the clean bag and Staff C completed personal care. On 8/2/24 at 12:50 PM Staff B stated that hand hygiene should be completed between each glove change and that hand sanitizer may be used for hand hygiene between glove changes. On 8/2/24 at 3:50 PM the Director of Nursing (DON) stated if a single staff member were completing personal care and needing to contain a large mess, hand hygiene between glove changes may not occur. However the DON recognized the standard of care is to perform hand hygiene between glove changes. The facility policy, Handwashing Protocol no date, revealed an alcohol-based hand rub containing at least 62% alcohol or soap and water should be used before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, and before and after removing non-sterile gloves.