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	07/24/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to inform residents of their options and costs when services were no longer covered by Medicare Part A for 3 of 3 residents reviewed (Resident #50, #43 and #5). The facility reported a census of 61 residents. Findings include:1) According to the Minimum Data Set (MDS) dated [DATE], Resident #50 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). The resident was totally dependent on staff for dressing, toileting, and hygiene. The Care Plan for Resident #50, last updated on 6/13/25, showed that staff would provide a restorative program 3-6 times a week due to parkinsonism. The diagnoses include intestinal obstruction, history of falling, anxiety disorder, and osteoporosis. The census tab in the electronic record indicated that Medicare Part A services ended on 4/10/25 for Resident #50, and on 6/12/25 the resident was private pay. A Beneficiary Protection Notification Review (BPNR) for Resident #50 showed that Form CMS (Centers for Medicare/Medicare Services) -10055 was not provided to the resident and lacked an explanation. 2) The MDS dated [DATE], showed that Resident #43 had a BIMS score of 12 (moderate cognitive deficit). The resident was totally dependent on staff for sit to stand and toilet transfers.The Care Plan updated on 5/21/25, showed the resident needed help with Activities of Daily Living (ADL) and planned to go home after working with Physical Therapy and Occupational Therapy (PT/OT). The diagnoses included chronic kidney disease, Type 2 diabetes mellitus and a history of urinary tract infections. According to the census tab in the electronic chart, Resident #43 had Medicare Part A coverage on 6/10/25 and private pay on 7/22/25. The BPNR indicated the last day of Medicare Part A for Resident #43 was 7/21/25 and the CMS-1055 Form was not provided to the resident. 3) According to the MDS dated [DATE], Resident #5 had a BIMS score of 9 (moderate cognitive deficit). He was totally dependent on staff for hygiene, toileting, dressing and transfers. The Care Plan revised on 3/14/25, showed the resident wanted to return home and he would participate in the restorative program due to muscle weakness. The census tab in the electronic chart showed Resident #43 had Medicare Part A services beginning 12/26/24, and was private pay on 2/13/25.A review of the BPNR documentation showed that Medicare Part A services ended on 2/12/25 and the resident was provided Form CMS-10055 to review the options. The chart lacked a 10055 form for Resident #5. On 7/23/2025 at 10:00 AM, the Social Worker (SW) said that she was fairly new to the position, and was not familiar with the CMS form 10055. She looked through the binder left behind by the previous SW and did not see any copies of the form. She did an internet search for the form, reviewed the questions and options presented to residents, and agreed that residents needed to know about the daily amount that would be expected if they chose to pay private and that they had the right to appeal. According to the undated, facility policy titled: Form Instructions, Advance Beneficiary Notice of Non-coverage (ABN); notifiers must complete the column under Blank (F) to ensure the beneficiary had all available information to make an informed decision about whether or not to obtain potentially non-covered services. The beneficiary or his or her representative must choose only one of three options listed in Blank (G). The beneficiary or representative must sign the notice to indicate that he or she had received the notice and understood its contents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review, observations, resident interview, and staff interview the facility failed to provide the residents with a comfortable / clean homelike environment. Resident rooms found with various debris on the floor and application of bed linen not completed in a timely manner for 3 of 24 residents reviewed (Resident #15, #22 and #24). The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #22 documented a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment. An observation on 7/21/25 at 11:52 AM of room [ROOM NUMBER]-B revealed a pile of sheets in the center of the bed. No sheets present in place on the bed. Review of document dated 7/24/25 titled, All Resident List documented Resident #22 resided in room [ROOM NUMBER] bed B. On 7/21/25 at 11:52 AM Resident #22 stated he got himself ready that morning. Resident #22 stated the staff usually get him ready but they did not that morning. Resident #22 stated he was not sure why the staff did not help him that morning but he can be impatient. Resident #22 stated the staff never came in to make the bed. Resident #22 stated he likes to lay down after breakfast but he was not able to that morning. Resident #22 stated the staff got his roommate up and made his bed but did not help him. Resident #22 stated he was very irritated. On 7/21/25 at 4:49 PM Staff F, Certified Nurse Assistant, (CNA) stated if the bed is due to be stripped that day then she strips the bed when she gets the resident up. Staff F explained then housekeeping will sanitize the bed and she would make the bed after breakfast. Staff F stated if the bed was not due to be stripped then she would make the bed when she got the resident up for the day. Staff F stated she did not have enough bottom sheets the morning of 7/21/25 so she did not make the beds in rooms 206, 216 first bed and 219-B until about 2:00 PM. On 7/21/25 4:55 PM Staff G, Certified Nurse Assistant (CNA) stated that morning (7/21/25) the facility did not have any bottom sheet available. Staff G stated laundry was behind that morning. Staff G stated housekeeping was normally in the building about 7am. Staff F stated room [ROOM NUMBER], 216 and 219 were the beds that did not have sheets that were not bed strips that morning. Staff G stated room [ROOM NUMBER]’s bed was made about 1:00 PM. Staff G stated the bottom sheets were not available until after 1:00 PM. Staff G stated laundry was made aware the CNA’s needed bottom sheets to make beds. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/25 at 12:26 PM Staff H, Laundry Assistant, Housekeeping Assistant, and Maintenance Employee acknowledged he worked in laundry on the morning of 7/21/25. Staff H stated he came into work at 7:00 AM that day. Staff H stated he typically came into work and took all the carts out of the laundry room, looked at the clothing covered barrels and put them into the washing machine. Staff H stated he then goes around collecting dirty linen and washing the linen. Staff H stated he did that routine twice a day, the second time between 10:00 AM and 10:30 AM. Staff H stated on 7/21/25 he asked the Director of Nursing (DON) if he should put more bottom sheets out for the staff. Staff H stated he washed the bottom sheets in the second load of that day and put the sheets out. Staff H stated the sheets were put out with the linen before lunch after 10:00 am. Staff H stated no one told him the residents did not have bottom sheets for their beds or asked him to wash bottom sheets. Staff H stated he noticed the amount of linen had been getting low that was why he asked to put the bottom sheets out. Staff H stated if he would have known the residents were out of bottom sheets and the staff needed bottom sheets to make beds he could have had the linen out about 9:30 AM or 10:00 AM. Staff H stated the staff do not run out of linen frequently but the last couple weeks the linen had been running low. On 7/23/25 at 12:37 PM the Administrator stated he heard on the morning of 7/21/25 that there was a process problem. The Administrator stated he needed to research the situation more. The Administrator stated he did not know if bottom sheets were left in the dryer or washer. The Administrator stated he placed a linen order today. The Administrator stated the facility was not out of linen. The Administrator stated nobody told him on 7/23/25 that there were no bottom sheets. The Administrator stated maybe on Sunday the laundry was not washed the way it should have been. The Administrator stated there was a lack of communication from staff and that was where the breakdown occurred. The Administrator stated the facility had enough linen. The Administrator stated he would expect the staff would have notified laundry or the Administrator there were no bottom sheets. The Administrator acknowledged the linen should have been on the bed prior to lunch. 2. Observation on 7/21/2025 at 10:25 AM, showed Resident #24’s floor with small, ripped pieces of paper, an unmade bed, and two pairs of shoes within the walking area. Resident #24 reported his shoes are never put away and the bed is unmade. The observation also showed the roommate's bed remained not made and four pieces of used Kleenex on the floor. Resident #24 reported the floor of the room is dirty five days a week. A follow up observation on 7/21/25 at 1:11 PM, showed Resident #24’s room to be in the same condition. 3. Observation on 7/21/25 at 1:11 PM, showed Resident #15’s room with 10 pieces of flattened cotton scattered on the floor. A follow up observation on 7/21/25 at 1:12 PM, showed Resident #15’s room to be in the same condition. An additional follow up observation on 7/22/25 at 9:22 AM, showed approximately 6 pieces of flattened cotton remained on the floor. A policy request for a homelike environment, routine housekeeping in rooms or application of bed linen was requested but not presented by the Administration.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to identify non-pharmacological interventions and targeted behaviors on the care plan related to high risk medications in 3 out of 5 sampled residents reviewed (Resident #2, #13 and #37). The facility reported a census of 61 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] for Resident #13 documented diagnoses of anxiety, dementia and Chronic Obstructive Pulmonary Disease (COPD). The MDS showed the Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The Clinical Physician Orders for Resident #13 showed the following orders:a. Morphine (opioid medication) every two as needed for pain or shortness of breath with a start date of 3/25/25.b. Lorazepam (antipsychotic medication) every four hours for restlessness/anxiety as needed with a start date of 5/29/25. The Care Plan identified Resident #13 was prescribed high risk medications for anxiety and pain. The Care Plan lacked non-pharmacological interventions to use prior to opioid medication usage and non-pharmacological interventions and targeted behaviors with antipsychotic medications. The July Medication Administration Record for Resident #13 showed Lorazepam administration occurred on the following dates:a. 7/7/25 at 11:02 PMb. 7/12/25 at 7:27 PM and at 11:30 PMc. 7/15/25 at 10:54 PM In an interview on 7/24/25 at 9:28 AM, Staff N, Registered Nurse (RN) reported that she would expect to find direction regarding non-pharmacological interventions to use prior to opioid medication usage and non-pharmacological interventions and targeted behaviors with antipsychotic medications. In an interview on 7/24/25 at 10:01 AM, the Director of Nursing, (DON) reported the care plan should include non-pharmacological interventions to use prior to opioid medication usage and non-pharmacological interventions and targeted behaviors with antipsychotic medications. The DON reported the facility usually placed the information on the Medication Administration Record and now planned to also include the same information on the care plans. 2. The MDS for Resident #2 dated 4/18/25 documented a BIMS score of 10/15 indicating moderate cognitive impairment. The MDS included diagnoses of Non-Alzheimer’s Dementia, traumatic brain disorder (TBI), anxiety disorder, depression, and psychotic disorder. The document identified no concerns with mood or behaviors during the reporting period. The MDS identified Resident #2 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. The electronic medical record (EMR) Medical Diagnoses printed 7/24/25 identified additional diagnoses of unspecified mood disorder, obsessive compulsive disorder (OCD), unspecified disorder of adult personality and behavior, delusional disorders, other specified mental disorders due to known physiological condition and personality change due to known physiological condition. Review of Resident #2’s 7/25 Medication Administration Record (MAR)-Treatment Administration Record (TAR) identified the resident was prescribed (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Risperidone 1 mg 1 tablet twice daily (BID) for unspecified mood (affective disorder) b. Sertraline 100 mg 2 tablets daily (QD) for depression c. Lorazepam 2mg/ml .25 ml every 4 hours as needed for anxiety The Physician Orders identified staff to monitor every shift for target behaviors: (refusal of cares, yelling out, physical aggression toward self/others, Spontaneous crying, False Beliefs, Wandering, and/or self-isolating. Document Interventions. 0-Not Present 1-Redirection 2-Music Therapy/Room Temp Adjustment. 3-1:1 4-Physical Touch/Repositioning 5-Offer Snack/Fluids 6-Remove resident from environment, date started 4/24/24. The facility failed to identify resident specific target behaviors for monitoring. Resident #2’s Care Plan dated 7/15/25 contained a Focus of medications considered high risk with interventions for staff including adverse reactions to psychotropic medications, adverse reactions to antidepressant medications, and adverse reactions to antianxiety medications. A focus of not keeping all diagnoses or medications initiated 2/3/25, had a goal of wanting the medical record to be part of the Care Plan. Interventions for staff included letting the physician know if they can do something to help, refer to medication list and warnings in the chart, and to see the medical chart if something is missing in this part of the chart dated 2/3/25. A focus of down in the dumps started 2/3/25 with a goal of wanting to be as happy as possible revised 7/15/25 revealed an Intervention of letting family and doctor know if it seems like mood is more down in the dumps created on 2/3/25. The Care Plan failed to identify target behaviors related to the use of psychotropic medications and non-pharmacological interventions. The Care Plan failed to have focus areas with goals and interventions related to psychiatric diagnosis. 3. The MDS for Resident #37 dated 6/25/25 identified a BIMS score of 3/15 indicating severe cognitive impairment. The MDS included diagnoses of Alzheimer’s, Non-Alzheimer’s Dementia, anxiety, and depression. The document identified mood feelings of feeling down, depressed, or hopeless in 2-6 days in the last 2 weeks of the reporting period. The MDS identified Resident #37 took antipsychotic, antianxiety and antidepressant medications during the last 7 days of the assessment period. Review of Resident #37’s 7/25 MAR-TAR identified the resident was prescribed: a. Donepezil 10 mg 1 tab QD for mood disorder b. Lorazepam 2 mg/ml .5 ml BID for anxiety disorder c. Olanzapine 10 mg 1 tab BID for major depressive disorder d. Sertraline 100 mg 2 tabs QD for mood disorder e. Lorazepam 2 mg/ml .75 ml every 2 hours as needed (PRN) for anxiety (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Orders identified staff to monitor every shift for target behaviors: (refusal of cares, yelling out, physical aggression toward self/others, Spontaneous crying, False Beliefs, Wandering, and/or self-isolating. Document Interventions. 0-Not Present 1-Redirection 2-Music Therapy/Room Temp Adjustment. 3-1:1 4-Physical Touch/Repositioning 5-Offer Snack/Fluids 6-Remove resident from environment, date started 10/14/24. The Physician Orders did not identify target behaviors related to the medications prescribed. Resident #37’s Care Plan dated 7/1/25 identified a focus of getting anxious dated 10/14/24 with a goal to be as happy as possible revised 7/1/25. The interventions for staff included to call family when anxious and to notify family and doctor if more down in the dumps/anxious dated 10/14/24. A focus of medications considered high risk dated 10/17/24 had a goal of no significant negative outcomes secondary to these medications with revision on 7/1/25. The interventions for staff included monitor/document/report PRN adverse reactions to psychotropic, antidepressant and antianxiety medications. A focus of not keeping all diagnoses or medications dated 10/17/24 with a goal of current medical record to be considered part of the Care Plan revised on 7/1/25 had interventions of notification to physician to let them know how they can help, medication list and warnings were in the chart, refer to other areas of the medical chart if there was something missing in this part of the chart. The Care Plan failed to identify the target behaviors related to the use of antipsychotic medications and depression. The document failed to identify person centered target behaviors related to anxiety. On 7/23/25 at 12:35 PM the MDS Coordinator stated a Care Plan Focus containing a down in the dumps statement would have different meanings for different residents depending on what they were going through. The staff stated the Care Plan Focus of not keeping all diagnoses or medications provided interventions for staff to refer to the medical chart for further information on behaviors for residents. The MDS coordinator acknowledged those focus areas and interventions neither provided individualization for each resident nor specifics related to use of antipsychotic medications and individualized target behaviors for either resident. On 7/23/25 at 2:08 PM the DON stated Care Plans should contain individualized behaviors for residents. The DON concurred generic statements of down in the dumps did not provide individualization for residents. On 7/24/25 at 10:50 AM the Administrator concurred general statements regarding behaviors did not identify specific behaviors related to antipsychotic, antidepressant or antianxiety medications for each resident. The facility’s policy, Goals and Objectives, Care Plans, undated, revealed Care Plan goals/objectives were resident oriented, behaviorally stated and measurable. It was noted that goals/objectives were entered on the resident’s Care Plan so all disciplines had access to the information and could report on whether the desired outcomes were being achieved. The facility did not provide a policy related to psychotropic medications.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, staff interview, and facility policy, the facility failed to ensure bed hold notice was sent to the resident and or the resident's responsible person when the resident transferred out of the facility for 1 of 1 residents reviewed (Residents #60). The facility reported a census of 61 residents. Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #60 documented a Brief Interview of Mental Status (BIMS) score of 14 indicating no cognitive impairment. Review of Resident #60's EHR documented no bed hold Review of Resident #60's EHR dated 5/14/25 at 9:27 PM titled, Progress Notes documented Resident #60 was transferred to the hospital with shortness of breath and chest pain with pain to the jaw and neck. Progress Note documented Resident #60 could not speak related to discomfort and Resident #60 requested to be transferred to the hospital. Resident #60's EHR titled, Progress Notes documented the resident remained at the hospital 5/15/25 or 5/16/25. On 7/24/25 at 11:10 AM the DON acknowledged the bed hold form was not completed for Resident #60. The DON stated after Resident #60 was sent to the hospital she had noticed there was no documentation of the bed hold in the progress note assessment related to Resident #60's hospital transfer. The DON explained when she questioned the social worker if the bed hold was completed she was told the bed hold was completed. The DON stated she had determined at the time later the bed hold form was not completed at all. The DON explained her expectation was that the bed hold would have been completed or the resident's representative would have been notified and the bed hold would have been completed over the phone. The DON acknowledged she could not find documentation that the bed hold was completed.On 7/24/25 at 11:15 AM the Administrator stated the facility's expectation was the bed hold would have been completed per the federal regulation and the facility's policy. The Administrator acknowledged that was not completed appropriately during Resident #60's transfer to the hospital on 5/14/25. The Administrator acknowledged Resident #60 was insured by managed Medicare coverage.Review of undated policy titled, Bed Hold Policy documented Medicare insurance did not offer bed hold coverage. Therefore, Medicare, Managed Medicare, and Private Pay residents may choose to hold the room, at the current room and board rates, until the resident's return to the facility. Resident/Resident's Representative must verify that they wish to have their bed held, within 24 hours of being admitted to the hospital, or their bed will be relinquished. Verification of bed-hold must be made prior to the start of a Resident's vacation or therapeutic leave from the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, document review, policy review and staff interviews the facility failed to provide a comprehensive care plan that included goals or interventions for residents with a catheter, depression and anxiety for 6 of 10 residents reviewed (Resident #1, #3 and #5, #6, #7 and #34). The facility reported a census of 61 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. Review of Resident #1's MDS dated [DATE] documented utilization of an indwelling catheter. Review of Resident #1's EHR titled, Care Plan revealed no focus, goal or intervention developed for utilization of a catheter. 2. The MDS dated [DATE] for Resident #3 documented a BIMS of 15 indicating no cognitive impairment. Review of Resident #3's MDS dated [DATE] documented utilization of an indwelling catheter. Review of Resident #3’s EHR titled, Care Plan revealed no focus, goal or intervention developed for utilization of a catheter. 3. The MDS dated [DATE] for Resident #5 documented a BIMS of 9 indicating moderate cognitive impairment. Review of Resident #5's MDS dated [DATE] documented utilization of an indwelling catheter. Review of Resident #5’s EHR titled, Care Plan revealed no focus, goal or intervention developed for utilization of a catheter. On 7/24/25 at 11:38 AM the DON acknowledged all of the residents at the facility that utilized catheters did not have care plans with a focus, goal or interventions related to the use of a catheter at that time. The DON stated her expectation was that a care plan would have been developed with a focus, goal and interventions related to the use of a catheter. On 7/24/25 at 11:19 AM the Administrator acknowledged the facility did not have things in place for Resident #6. The Administrator stated the care plans for the residents with catheters could have been entered today and the facility had written the PIP (performance improvement plan) with a target completion date of 7/25/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an undated policy titled, Goals and Objectives, Care Plans documented Care plan goals and objectives are defined as the desired outcome for a specific resident problem. Care plan goals and objectives are derived from information contained in the resident’s comprehensive assessment and : are resident oriented, are behaviorally stated, are measurable and contain timetables to meet the resident’s needs in accordance with the comprehensive assessment. Goals and objectives are entered on the resident’s care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. 4. The MDS assessment dated [DATE] for Resident #6 documented reentry into the facility on 7/17/25 from a short term hospital stay. In an interview on 7/23/25 at 9:36 AM, Resident #6 reported the catheter was inserted at the hospital because she had surgery for a right foot fracture related to a fall. The resident reported the hospital kept the catheter inserted because she was non-weight bearing. The Medical Diagnosis report for Resident #6 included diagnoses of a closed fracture of the lower end right tibia and urinary retention. The Hospital Discharge Instructions for Resident #6 dated 7/14/25 showed diagnoses of a major ankle injury and closed fracture of distal end of the right fibula and tibia. The Progress Note dated 7/17/25 at 3:39 PM showed the facility received report from the hospital that Resident #6 had a right ankle fracture with right lower leg wrapped, foley catheter placed and the resident’s activity level would be two person assist and non-weight bearing to right side. The Care Plan for Resident #6 failed to show an updated activity level of non-weight bearing to the right side, a presence of a catheter, or information regarding the fracture of the right tibia and fibula. On 7/24/25 at 11:38 AM the DON acknowledged all of the residents at the facility that utilized catheters did not have care plans with a focus, goal or interventions related to the use of a catheter. The DON stated her expectation was that a care plan would have been developed with a focus, goal and interventions related to the use of a catheter. The DON stated Resident #6 does now have an order for a catheter. The DON acknowledged the facility did not have an order in place prior to surveyors entrance at the facility. On 7/24/25 at 11:19 AM the Administrator acknowledged the facility did not have things in place for Resident #6. The Administrator reported the orders and diagnosis should not take that long. The Administrator acknowledged the Resident #6 did not have a care plan related to catheter with interventions. The Administrator stated the care plans for the resident with catheters could be entered today. 5. The MDS for Resident #7 dated 6/20/25 identified a Brief Interview for Mental Status (BIMS) score of 13/15 indicating normal cognition. The MDS included diagnoses of anxiety, and depression. The document identified no areas of behavior or mood during the reporting period. The MDS identified Resident #7 took antianxiety and antidepressant medications during the last 7 days of the assessment period. Review of Resident #7’s MAR-TAR dated 7/25 identified the resident was prescribed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Alprazolam .25 mg three times a day (TID) for anxiety written 7/21/25. Bupropion XL 150 mg extended release (ER) daily (QD) written 9/12/23 and revised 12/17/24. The Physician Orders provided to monitor every shift for target behaviors: (refusal of cares, yelling out, physical aggression toward self/others, Spontaneous crying, False Beliefs, Wandering, and/or self-isolating. Document Interventions. 0-Not Present 1-Redirection 2-Music Therapy/Room Temp Adjustment. 3-1:1 4-Physical Touch/Repositioning 5-Offer Snack/Fluids 6-Remove resident from environment written 12/6/23. The Physician Order for documentation of target behaviors was not individualized to the resident. Review of EMR Progress Notes 1/1/25 to 7/24/25 revealed entries for provision of Alprazolam .25 mg as needed up TID for resident complaints of anxiety. The entries did not provide description of anxiety signs or symptoms. The facility provided document, Psychiatric Note dated 5/20/25, revealed Resident #7 received Individual Psychotherapy due to a mental health diagnosis of generalized anxiety disorder. The document disclosed the resident presented with symptoms of anxiety, fatigue, goal-directed activity decreased, sleep decreased and socially isolating. Resident #7's Care Plan dated 6/25/25 revealed a focus of inability to keep all diagnoses or medications initiated on 9/16/24. The interventions for staff included to notify the doctor of what they can do to help, medications and warnings were located in the chart, and to look at other areas of the medical chart if something was missing. An additional focus identified high risk medications dated 9/30/24 had staff interventions of identification of adverse reactions to antianxiety and antidepressant medications. The Care Plan failed to identify target behaviors related to the use of antianxiety medications and antidepression medications. The document further failed to identify non-pharmacological interventions related to the use of the medications. 6. The MDS for Resident #34 dated 5/22/25 identified a BIMS score of 10/15 indicating moderate cognitive impairment. The MDS included a diagnosis of non-Alzheimer’s Dementia. The document identified no signs/symptoms of mood, but identified wandering 1-3 days during the reporting period. The MDS identified Resident #34 took antidepressant medication during the last 7 days of the assessment period. The EMR Medical Diagnoses revealed a diagnosis of insomnia dated 6/3/25. Review of Resident #34’s MAR-TAR 7/25 identified the following orders: Trazodone 100 mg for insomnia dated 4/18/25. Duloxetine 30 mg for unspecified dementia dated 1/17/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An order for recording the number of hours slept related to unspecified dementia contained data from 2 hours to 8+ hours. An order was provided to monitor every shift for target behaviors: (refusal of cares, yelling out, physical aggression toward self/others, Spontaneous crying, False Beliefs, Wandering, and/or self-isolating. Document Interventions. 0-Not Present 1-Redirection 2-Music Therapy/Room Temp Adjustment. 3-1:1 4-Physical Touch/Repositioning 5-Offer Snack/Fluids 6-Remove resident from environment written 10/15/24. The Physician Order of monitoring of target behaviors was not resident specific. A facility document, Pharmacy Note to Attending Physician/Prescriber dated 2/26/25, revealed the use of Trazodone for insomnia and Duloxetine for depression could be seen as duplicative therapy as both medications were classified as antidepressants. The document contained statements that Trazodone was a dual purpose medication utilized for treatment of insomnia and the provider indicated the use of both antidepressants outweighed the risks. Resident #34’s Care Plan revealed a focus for medications identified as high risk dated 11/18/24. Staff interventions revealed side effects of antidepressant medication included insomnia dated 11/18/24. A focus of down in the dumps dated 11/18/24 revealed an intervention for staff to let family and doctor know if the resident’s mood was more down in the dumps dated 11/18/24. A focus of inability to keep all diagnoses or medications dated 11/18/24. The interventions for staff included to notify the doctor of what they can do to help, medications and warnings were located in the chart, and to look at other areas of the medical chart if something was missing. The Care Plan failed to identify the use of medications classified as antidepressants for uses other than depression and resident specific behaviors related to them, and resident specific behaviors related to being down in the dumps. On 7/23/25 at 12:35 PM the MDS Coordinator stated the Care Plan Focus of down in the dumps was dependent upon the resident and what they were going through. The staff recognized the focus area related to not keeping all diagnoses or medications and interventions to refer to medical charts, let the doctor know what they can do to help, medication lists/warnings were in chart, and refer to other areas of the medical chart if something was missing in this area of the chart was not personalized to an individual resident as it was on multiple residents’ charts. The staff stated with the Focus and intervention it directed people to look in the chart for identified behaviors which could be located in the Depression Screening if the resident had one. The staff acknowledged she could not easily identify anxiety or depression behaviors for either of the residents. On 7/23/25 at 2:08 PM the Director of Nursing (DON) stated a Care Plan Focus of down in the dumps could be an identified area of concern but expected the Interventions identify the specific signs/symptoms or target behaviors for depression and/or anxiety. The DON concurred if behaviors were identified in the EMR in assessments they should be identified in the Care Plan. On 7/24/25 at 10:50 AM the Administrator concurred general statements regarding behaviors (example down in the dumps) did not identify specific behaviors related to an individual. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility’s policy, Goals and Objectives, Care Plans, undated, revealed Care Plan goals/objectives were resident oriented, behaviorally stated and measurable. It was noted that goals/objectives were entered on the resident’s Care Plan so all disciplines had access to the information and could report on whether the desired outcomes were being achieved.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interviews, record review and policy review the facility failed to obtain and follow physicians' orders for 2 of 21 of residents (Resident #36 and #6). Staff chose to hold insulin for Resident #36 without obtaining doctor-specified parameters on when to hold the insulin and failed to notify the doctor when the insulin hadn't been given. Resident #6 had an indwelling urinary catheter, staff failed to obtain an order for the device. The facility reported a census of 61 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #36 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). He was independent with hygiene, toileting, dressing, transferring and walking. His diagnoses included: diabetes mellitus, renal insufficiency, schizophrenia, anxiety disorder and adult failure to thrive. The Care Plan updated on 5/1/25, showed that Resident #36 needed a therapeutic diet related to diagnosis of diabetes mellitus. Staff were to monitor blood sugars as ordered. The Care Plan lacked directive for insulin use. The orders tab in the electronic chart showed that Resident #36 had an order dated 3/24/25 at 7:30 AM, for a fast-acting insulin to be give three times a day, before his meals. In an observation on 7/22/25 at 9:01 AM, Staff B Licensed Practical Nurse (LPN) prepared 5 units of fast acting insulin, and brought it to the resident in his room. Resident #36 was in bed and said that he had completed his breakfast, and the kitchen staff had already picked up the tray. A review of the Medication Administration Record (MAR) for June and July, showed that on the following dates, the fast acting insulin was not given to Resident #36: June 9th, 12th, 15th, 17th, 18th, 23rd, 24th, 27th, and 30th. July 5th, 8th, 13th, 15th, 18th, 21st, and 23rd. The Nursing Progress Notes lacked documentation that the physician had been notified the insulin had been held on these dates. A review of the Blood Sugar Summary for Resident #36 revealed that from June 1 – July 22, the readings did not go below 81 milligrams per deciliter (normal range being 70-100 mg/dL.) On 7/23/25 at 9:32 AM, Staff C, Registered Nurse (RN) said that she chose not to give Resident #36 his short acting insulin that morning because his blood sugar was low. She said she used her nursing judgement to decide that the blood sugar was too low. Staff C acknowledged that there were no doctor-ordered blood glucose parameters established, but she agreed that it would be helpful. She did not know how other nurses determined or decided when to hold the insulin. On 7/23/2025 at 9:19 AM Staff B, Licensed Practical Nurse (LPN) said that Resident #36 tended to have low blood glucose in the mornings, and he was getting Glucerna but the doctor hadn’t established any parameters on when to hold his insulin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/2025 at 3:30 PM, the Nurse Practitioner (NP) acknowledged that there weren’t blood sugar parameters established for Resident #36, and she wasn’t aware of how often the insulin was being held. On 7/23/2025 at 10:50 AM, the Director of Nursing (DON) agreed that they should have asked the doctor for directives on when to hold the short acting insulin. She said that the nurses should have called to let the doctor know when the medication was being held. 2) The MDS assessment dated [DATE] for Resident #6 documented reentry into the facility on 7/17/25 from a short term hospital stay. In an interview on 7/23/2025 at 9:36 AM, Resident #6 reported the catheter was inserted at the hospital because she had surgery for a right foot fracture related to a fall. The resident reported the hospital kept the catheter inserted because she was non-weight bearing. The Medical Diagnosis report for Resident #6 included urinary retention. The Progress Note dated 7/17/25 at 3:39 PM showed the facility received report from the hospital that Resident #6 would return with a foley catheter placed. The Progress Note dated 7/19/25 at 2:06 PM for Resident #6 showed the catheter to be patent and draining yellow urine. The Clinical Physician Orders for Resident #6 failed to show orders related to a foley catheter. The Physician Orders policy last revised on January 2024 identified the following: It is the policy of this facility to secure physician orders for care and services for residents as required by state and federal law. Physician orders will be dated and signed according to state and federal guidelines. PROCEDURE- Physician orders will include the medication and/or treatment and a correlating medical diagnosis or reason. Medication orders will include: Name of drug Route Dosage Frequency Diagnosis Stop date (i.e., antibiotics) if appropriate (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unclear or incomplete written orders will be reviewed with the physician. Any order clarification will be documented on the Physician’s Telephone Order form. Faxed orders will be accepted under the following conditions: Physician signs and retains the original copy of the faxed order. Physician provides the original copy, if requested. It is not necessary for the physician to re-sign the facsimile order unless required by State law. The original may be sent to the facility at a later time and substituted for the facsimile copy. With order changes, discontinue the current order prior to initiating the new order. Inform resident/responsible party and/or family member of changes in physician orders. Communicate orders to the pharmacy, as applicable. On 7/24/25 at 11:38 AM the DON stated Resident #6 does now have an order for a catheter. The DON acknowledged the facility did not have an order in place prior to surveyors entrance at the facility. On 7/24/25 at 11:19 AM the Administrator acknowledged the facility did not have things in place for Resident #6. The Administrator reported the orders and diagnosis should not take that long. The Administrator stated the orders for all the residents should be entered at this time. The Administrator stated the facility does not have routine orders and needs to have routine orders especially for catheters.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, electronic medical record (EMR) reviews, staff interviews, and policy review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for 1 of 1 residents reviewed, requiring the use of oxygen (Resident #47). The facility reported a census of 61 residents. Findings include: The Minimum Data Set (MDS) for Resident #47 dated 7/17/25 identified a Brief Interview for Mental Status (BIMS) score of 12/15 indicating moderate cognitive impairment. The MDS documented diagnoses that included: heart failure, hypertension, anxiety disorder, obstructive sleep apnea, and pulmonary hypertension. The document provided the resident utilized oxygen upon admission and while a resident, and that oxygen was continuous on admission.Resident #32's Care Plan dated 7/23/25 identified a focus area of oxygen therapy related to ineffective gas exchange. Interventions for staff included oxygen at 3-5 liters (L). The 7/25 Medication Administration Record (MAR)-Treatment Administration Order (TAR) did not provide orders or instructions for changing oxygen tubing. On 7/21/25 at 10:23 AM Resident #47 stated she utilized oxygen at 3L since 2018.Observed on 7/21/25 at 10:23 AM the resident with a nasal cannula and undated oxygen tubing.Observed on 7/22/25 at 2:40 PM the resident's concentrator outside of the bathroom set at 3L with undated oxygen tubing.Observed on 7/23/25 at 1:00 PM Resident #47's oxygen tubing was undated. On 7/23/25 at 2:40 PM the Director of Nursing (DON) stated that oxygen tubing was changed on Monday nights as part of the Nigh Shift responsibilities. The DON stated upon further document review there should have been an order for oxygen tubing change. Review of Resident #47's MAR-TAR the DON acknowledged there was no order for tubing replacement. On 7/24/25 at 10:50 AM the Administrator expected there should be a way to audit the changing of oxygen tubing. On 7/24/25 at 12:46 PM the Administrator revealed the facility did not have an oxygen tubing policy, but rather they followed manufacturer recommendations. The Administrator indicated nasal cannulas be changed every 2 weeks and supply tubing every month, and the facility expectation is it be changed every week currently.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, staff interviews, Electronic Medical Record (EMR) review, and policy review, the facility failed to provide appropriate treatment and services to meet a resident's highest practicable physical, mental, and psychosocial well-being for a resident diagnosed with dementia for 1 of 1 residents reviewed (Resident #37). The facility had a census of 61. Findings include:The Minimum Data Set (MDS) for Resident #37 dated 6/25/25 identified a BIMS score of 3/15 indicating severe cognitive impairment. The MDS included diagnoses of Alzheimer's, Non-Alzheimer's Dementia, anxiety, and depression. The document identified mood feelings of feeling down, depressed, or hopeless in 2-6 days in the last 2 weeks of the reporting period. The MDS identified Resident #37 took antipsychotic, antianxiety and antidepressant medications during the last 7 days of the assessment period.The 7/25 Medication/Treatment Administration Record (MAR-TAR) identified an order dated 10/14/24 for nursing to monitor every shift for target behaviors: (refusal of cares, yelling out, physical aggression toward self/others, Spontaneous crying, False Beliefs, Wandering, and/or self-isolating. Document Interventions. 0-Not Present 1-Redirection 2-Music Therapy/Room Temp Adjustment. 3-1:1 4-Physical Touch/Repositioning 5-Offer Snack/Fluids 6-Remove resident from environment.The Physician's Order failed to be individualized to Resident #37's diagnosis of dementia and behaviors associated with the diagnosis.Resident #37's Care Plan dated 7/1/25 identified a focus dated 10/14/24 of the resident being a social butterfly with the goal to remind/invite the resident to activities revised on 7/1/25. Interventions for this focus included providing assistance during the activities, inviting the resident to the activities, and activities the resident enjoyed. A 7/1/25 revised focus revealed the resident did not do very well on the memory test due to being forgetful with a goal of the resident making as many decisions as possible with the family helping revised 7/1/25. Interventions dated 10/17/24 for the focus included notification to the Power of Attorney (POA) with updates/need for important decisions to be made and the resident requires reminders sometimes. The Care Plan failed to identify Resident #37's specific diagnosis of dementia and specific interventions related to that diagnosis. The Care Plan failed to provide revisions to reflect the change in the resident's abilities to participate and complete tasks, techniques for staff to intervene with the resident, and goals that were measurable. The EMR review of activities completed during the previous 30 days found the following:a.) Group Activities - the resident attended 2/15 opportunities offered, and refused 13/15 opportunities offered.b.) One to Once Activities - 0 activities documented.c.) Independent Activity - 0 activities documented.On 7/21/25 from 9:45 AM - 11:30 AM observed Resident #37 awake and seated at the nurses station in a tilt and space wheelchair without any activities.On 7/22/25 at 9:54 AM observed Resident #37 sleeping at the nurses station.On 7/22/25 at 10:50 AM observed Resident #37 sleeping during a group activity. On 7/22/25 at 2:38 PM observed Resident #37 seated at the nurse's station, awake and without an activity while a group activity was happening. On 7/23/25 at 9:33 AM Staff D, Certified Nurses Assistant (CNA), stated Resident #37 tends to get out of her wheelchair (w/c) so the staff will place her at the nurses station for closer monitoring. The staff stated sometimes they will give the resident an activity to do. Staff D stated the resident will do a sewing activity or an interactive activity with lights and colors, but some activities were broken. Staff D stated she has asked the resident to select all objects of a color and the resident could complete. On 7/23/25 at 9:45 AM Staff B, Licensed Practical Nurse (LPN), stated residents who were at higher fall risk may sit around the nurses station for heightened awareness. The staff stated some residents will engage with each other, watch people, or do activities. The staff stated activities were kept at the nurses station in cubbies for staff to provide to the residents. Staff B stated when a resident was observed to be sleeping they would ask staff to take the residents back to their rooms to lie down. On 7/23/25 at 9:50 AM the Director of Nursing (DON) stated high fall risk residents may be placed at the nurses station for increased safety awareness as there were more staff in that area. The staff stated the residents will engage with each other and if they were noted to be sleeping they should go back to their rooms to lie down. The DON acknowledged that residents should be offered activities and some residents like to watch people. On 7/23/25 at 12:35 PM the MDS Coordinator stated there was not a specific focus on the Care Plan related to the diagnosis of dementia. The staff stated there might be a cognition focus with interventions including whether a resident could participate, acknowledging all residents can participate at some level, and how to assist the resident to participate. The MDS Coordinator stated a goal could be wanting to make her own decision or having family help make that decision, and the intervention would be reminding the staff the resident can tell staff what they want or need. When asked about Resident #37 sitting

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, document and policy review the facility failed to provide food at an appetizing temperature to 4 of 24 residents reviewed (Resident #1, #11, #20 and #27). The facility reported a census of 61 residents.Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #11 documented a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 7/21/25 at 10:57 AM Resident #11 stated she ate all of her meals in her room. Resident #11 explained that at least twice a week the food is brought to her room cold. Resident #11 stated the staff leave before she eats and she does not turn the light on to have them reheat the food. Resident #11 stated no specific meal is cold but all have been. Resident #11 stated the meals have been brought to her room cold a couple times in the last week. 2. The MDS dated [DATE] for Resident #20 documented a BIMS of 9 indicating moderate cognitive impairment. On 7/21/2025 at 10:44 AM Resident #20 stated the food was brought to his room cold about twice a week. Resident #20 stated he ate all of his meals in his room. On 7/21/25 at 12:22 PM an observation of the lunch meal service revealed room trays were being plated with the last lid applied at 12:24 PM. Request for sample tray with tray placed in place of the first tray that was put on the delivery cart. Sample tray taken to the kitchen just after the first room tray was delivered to resident. The temperature from the food on the sample tray checked by Staff I, [NAME] was; ham 105 degrees, cauliflower 124.5 degrees and sweet potato fries 109.6 degrees. Staff J, Certified Dietary Manager (CDM) present when temperatures of the test tray was obtained. On 7/21/25 at 12:31 PM Staff J, CDM acknowledged the food temperatures were less than she expected. Staff J stated the room trays are usually hotter than today’s service. Staff J explained she felt the food delivered to the residents rooms should be above 130 degrees. On 7/22/25 at 2:01 PM Staff K, Registered Dietitian (RD) stated the point of service food needs to be 140 degrees delivered to the resident. On 7/22/25 at 3:27 PM the Administrator stated he did not believe there was an exact temperature for the food to get to the resident in their rooms with room trays. The Administrator stated palatability is different for each resident. The Administrator stated he did not think Staff K had given the correct answer for point of service temperatures. The Administrator stated he did not know how to fix an issue that he was unaware of. The Administrator stated he had not heard any of the residents complain about the food temperatures at the facility. Review of document titled, FDA Food Code 2022 documented Time – maximum up to 4 hours (B) If time without temperature control is used as the public health control up to a maximum of 4 hours: (1) Except as specified in (B)(2), the FOOD shall have an initial temperature of 5°C (41ºF) or less when removed from cold holding temperature control, or 57°C (135°F) or greater when removed from hot holding temperature control. (continued on next page)

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	165290	A. Building B. Wing	07/24/2025

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy dated 12/4/24 titled, Resident Nutrition Services provided by the Administrator documented to minimize the risk of foodborne illness, the time that potentially hazardous foods remain in the “danger zone” (41 to 135) will be kept to a minimum. Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than 2 hours will be discarded. 3. The MDS dated [DATE] for Resident #27 documented a BIMS of 12 which indicated moderate cognitive impairment. The MDS identified Resident #27 understood and expressed ideas and wants. The Care Plan for Resident #27 indicated a regular diet. On 7/21/25 at 11:44 AM Resident #27 reported the meat is often tough, dry, cold and hard to chew. The resident stated, I just don't eat it. When asked how often this occurred per week the resident replied, all the time. The resident reported the vegetables are not hot, half cooked, cold and rubbery. The resident consumes meals in her room. 4. The MDS dated [DATE] for Resident #1 revealed a BIMS score of 8/15 indicating moderate cognitive impairment. The MDS included diagnoses of benign prostatic hyperplasia, renal insufficiency/failure/end stage renal disease, neurogenic bladder, cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke. The document revealed the resident ate with supervision or touching assistance. The resident’s Care Plan dated 7/2/25 identified an activities of daily living (ADL) focus dated 4/18/25 and the interventions for staff did not indicate staff needed to assist the resident. On 7/21/25 at 12:10 PM Resident #1 stated that sometimes the food is cold when he gets it. The resident stated he may eat in his room. The resident stated he had a Reuban sandwich that was “cold like the icebox”, and did not have sauerkraut or Thousand Island dressing. On 7/24/25 at 10:55 AM the Administrator acknowledged he had heard a concern during the survey process of complaints of food temperatures. The Administrator stated that palatable for residents was subjective, and that he had not had any complaints regarding food temperatures from residents or from Resident Council.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on document review, staff interviews, and facility plan review the facility failed to demonstrate good faith attempts to correct quality deficiencies based on issues that were identified with repeat deficiencies in 3 areas and corrections developed in a Performance Improvement Plan (PIP) that remained incomplete in a reasonable time frame. The facility reported a census of 61 residents. Findings include:Review of document titled, Provider History Report documented previous recertification survey on 9/18/24 with deficiencies F0625 notice of bed hold policy before/upon transfer with a correction date of 10/19/24, F0656 Develop/implement Comprehensive care plan with correction date of 10/19/24, and F0658 services provided meet professional standards with correction date of 10/19/24.Review of document dated 7/7/25 titled, Performance Improvement Plan (PIP) documented an objective and goal to meet and maintain compliance with F880. Also documented actions steps to ensure noted catheters have appropriate orders and care plans with a target completion date of 7/25/25.On 7/24/25 at 11:38 AM the DON acknowledged all of the residents at the facility that utilized catheters did not have care plans with a focus, goal or interventions related to the use of the catheter. The DON stated her expectation was that a care plan would have been developed with a focus, goal and interventions related to the use of a catheter. The DON acknowledged the facility did not have an order in place for one of the residents prior to surveyors entrance at the facility.On 7/24/25 at 11:19 AM the Administrator explained the PIP about federal regulation tag 880 was a result of a mock survey and received the results of the survey on 7/18/25. The Administrator acknowledged the orders for the catheter that had not been entered prior to the survey team entrance on 7/21/25 should not have taken that long to enter. The Administrator stated the target date can be changed and extended if the PIP did not meet the goal date. The Administrator stated the facility does not have routine orders and needs to have routine orders especially for catheters. The Administrator acknowledged the resident that he reviewed did not have a care plan related to catheter with focus, goals and interventions documented. The Administrator stated the care plans for the resident with catheters could be entered by the day's end and the facility had written the PIP for a target completion date of 7/25/24. The Administrator stated he felt he was going to receive a regulatory violation related to repeat deficiencies for QAPI.Review of the document dated 3/19/25 titled, Quality Assurance and Performance Improvement Program documented North Crest Living Center Quality Assurance and Performance Improvement Committee abides by guiding principles that included setting goals for performance and measured progress towards those goals. With goals that included striving for a deficiency free survey and monthly meetings with review of correction compliance for plans of correction.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow infection control standards of practice. Laundry staff failed to wear Personal Protective Equipment (PPE) while sorting laundry, and the facility failed to ensure that they had consistent implementation of the responsibilities of the Infection Preventionist (IP). The facility reported a census of 61 residents. Findings include:On 7/24/25 at 6:48 AM, observed Staff L, Environmental Aide in the laundry room sorting dirty laundry items without a gown or gloves. She quickly went to get a gown but was unsure how to put it on. She first put it on backwards, with the ties in the front, then she took it off and put it on the correct way with the ties in the back. She went back to sorting the laundry but failed to apply disposable gloves. On 7/24/25 at 8:15 AM, the Director of Nursing (DON) explained that she was taking over the responsibilities as Infection Preventionist as they discovered that the Assistant Director of Nursing (ADON) was not completing the required tasks and was terminated. She said that she found residents that should have been on Enhanced Barrier Precautions (EBP) did not have signage at the doors or appropriate PPE. Some had signage that didn't need to be on EBP. The DON maps of infections for April and May but none for June or July. According to the facility policy titled: Infection Prevention and Control Program revised on 1/2024. The designated Infection Preventionist (IP) serves as a consultant to our staff on infectious diseases, resident room placement implementing of isolation precautions, staff and resident exposures, surveillance and epidemiological investigations of exposure of infectious diseases. The intent of the regulation was to ensure that the facility develops and implements protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic. Laundry and direct care staff shall handle, store, process, and transport linens so as to prevent spread of infection. The Facility assessment dated [DATE] showed that the Services Provided included infection prevention and control. Identification and containment of infections, prevent of infections, Antibiotic stewardship and isolation precautions.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on staff interview, record review and policy review the facility failed to ensure they followed through with antibiotic stewardship practices. The facility reported a census of 61 residents. Findings include:On 7/24/25 at 8:15 AM, the Director of Nursing (DON) explained that she took over the responsibilities as Infection Preventionist (IP) early in June as she discovered that the previous IP was not completing the tasks as directed. She displayed a spreadsheet that she recently developed to use for antibiotic tracking. The spreadsheet lacked any resident information. When asked how any residents were on an antibiotic, she looked through the electronic chart and said there was just one resident. She was not aware of any tools that the nurses were using, such as the McGeer (criteria for infection surveillance) that could help them determine the resident's need for antibiotics. According to the Department of Health and Human Services Centers for Medicare and Medicaid Services Resident Matrix, provided at the start of the recertification, the facility had 6 residents that were on antibiotics at the time of survey. According to the facility policy titled: Infection Prevention and Control Program revised on 1/2024, the designated IP served as a consultant to the staff on infectious diseases, resident room placement implementing of isolation precautions, staff and resident exposures, surveillance and epidemiological investigations of exposure of infectious diseases. The intent of the regulation was to ensure that the facility developed and implemented protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic are prescribed the appropriate antibiotic. The facility would develop promote and implement a facility wide system to monitor the use of antibiotics.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to ensure that staff obtained signed consents and were educated on the influenza immunization before it was administered. The facility reported a census of 61 residents.Findings include:1) According to the Minimum Data Set (MDS) dated [DATE], Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). His diagnoses included arthritis, non-Alzheimer's Dementia, anxiety disorder and cerebrovascular disease. The Care Plan for Resident #11, updated on 11/12/24, showed that her immune system had aged and staff were to encourage the resident to follow current guidelines for influenza and pneumonia vaccines. The tab titled: Vaccines, showed that Resident #11 received the Influenza vaccine on 10/3/24. The chart lacked a consent and documentation that education had been provided. 2) The MDS dated [DATE], indicated that Resident #7 had a BIMS score of 13 (moderate cognitive deficits). She was totally dependent on staff for hygiene, dressing, toileting and transferring. The Care Plan updated on 3/26/25, showed that she had a compromised immune system, the resident would be encouraged to meet the current guideline for influenza vaccines. The tab titled: Vaccines, showed that Resident #7 had the Influenza vaccine on 10/7/24. The chart lacked a consent and documentation that education had been provided. 3) The MDS dated [DATE] for Resident #14 showed that she had a BIMS score of 15 (intact cognitive ability). She was independent with toileting, dressing, hygiene, transfers and walking. The Care Plan updated on 10/1/24 showed that the resident was on supplemental oxygen therapy related to Congestive Heart Failure (CHF). The tab titled: Vaccines, showed that Resident #14 received the Influenza vaccine on 10/8/24. The chart lacked a signed consent or documentation that education had been provided. On 7/23/25 at 10:50 AM, the Director of Nursing (DON) said that she recognized that immunization processes needed improvement and she was working on a Performance Improvement Plan (PIP). Immunizations would be addressed in the IDT meetings and they would give consent and education at that time for the upcoming influenza season. She said that they were electronically signed but she didn't have documentation that education was provided. The Administrator said that with verbal consent, he would like to see that there were 2 witnesses and he preferred that there was actually signatures not just verbal. The DON came back later after looking through notes and found that the plan she had for the care plan meetings was not being followed through with and the residents were not always given education. She pointed to the PIP they have established related to federal tag 880 concerns and they have immunizations listed, however, consents and educations were not specifically noted on the PIP but she said she would get to it as she would be going through the immunization needs. I asked for a policy on signed vs. verbal consents. they were going to look. According to the facility policy titled: Influenza Vaccine; dated 6/2024, prior to the vaccination, the resident or resident's legal representative, would be provided information and education regarding the benefits and potential side effects of the influenzas' vaccine. Provision of such education would be documented in the resident's medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and policy review the facility failed to ensure that staff obtained signed consents and were educated on the COVID-19 immunization before it was administered. The facility reported a census of 61 residents.Findings include:1) According to the Minimum Data Set (MDS) dated [DATE], Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). His diagnoses included arthritis, non-Alzheimer's Dementia, anxiety disorder and cerebrovascular disease. The Care Plan for Resident #11, updated on 11/12/24, showed that her immune system had aged and staff were to encourage the resident to follow current guidelines for COVID-19 vaccines. The tab titled: Vaccines, showed that Resident #11 received the COVID-19 vaccine on 10/3/24. The chart lacked a consent and documentation that education had been provided. 2) The MDS dated [DATE], indicated that Resident #7 had a BIMS score of 13 (moderate cognitive deficits). She was totally dependent on staff for hygiene, dressing, toileting and transferring. The Care Plan updated on 3/26/25, showed that she had a compromised immune system, the resident would be encouraged to meet the current guideline for COVID-19 vaccines. The tab titled: Vaccines, showed that Resident #7 had the COVID-19 vaccine on 11/4/24. The chart lacked a consent and documentation that education had been provided. 3) The MDS, dated [DATE] for Resident #14, showed that she had a BIMS score of 15 (intact cognitive ability). She was independent with toileting, dressing, hygiene, transfers and walking. The Care Plan updated on 10/1/24 showed that the resident was on supplemental oxygen therapy related to Congestive Heart Failure (CHF). The tab titled: Vaccines, showed that Resident #14 received the COVID-19 vaccine on 11/4/24. The chart lacked a signed consent or documentation that education had been provided. On 7/23/25 at 10:50 AM, the Director of Nursing (DON) said that she recognized that immunization processes needed improvement and she was working on a Performance Improvement Plan (PIP). The plan lacked specifics related to immunizations, but it would be addressed, and planning would take place during the Interdisciplinary Team (IDT) meetings in July. She thought that the residents could give consent and would be provided education at that time for the upcoming influenza season. The DON said that consents were electronically signed but she didn't have documentation that education was provided and did not include a second witness for verbal consents. The Administrator said that with verbal consent, he would like to see that there were 2 witnesses and he preferred that there were actual signatures not just verbal. According to the facility policy titled: Utilization of Vaccinations, last revised on 1/2024; Consent for the COVID vaccine would be acquired from the resident and physician. The Immunization Informed Consent Record included an attestation that the resident received relevant vaccine information that provided current Center for Disease Control (CDC) information about vaccines and that the resident elected to receive the vaccine. The benefits and potential side effects had been explained and the resident understood the information. A signed and dated copy of the form would be placed in the resident's permanent medical record.