STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165338	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Care Center	960 4th Street NW Waukon, IA 52172

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, video footage review, clinical record review, staff interview and review of the facilities Resident [NAME] of Rights, the facility failed to maintain the dignity and respect during cares for 2 of 3 residents reviews. (Resident #3 and Resident #4). The facilities identified a census of 45 residents. Findings include: 1. Review of the video footage revealed the following: a. 8:26:17 p.m. - As Resident #3 sat positioned in a recliner chair in the dining/lounge area, Staff A, Licensed Practical Nurse (LPN) approached the resident, pulled out her sweat pants at the waist band area, placed her hands inside the sweat pants and palpated the resident's left hip area following a fall as another resident sat approximately12 feet right across from Resident #3 in direct view. Review of the facilities timeline of events provided from the video footage included the following: a. 7:49:40 p.m. - Staff A pressed on the resident's left hip area. b. 7:50:34 p.m. The nurse looked under the resident's pajama bottoms as if she looked for any bruising or injury and pressed on the resident's hip. c. 7:51:30 p.m. - The nurse finished with the resident and walked away. d. 7:52:42 p.m. - The nurse walked back to the resident after she applied gloves at the medication cart and again palpated or rubbed the resident's left hip area. 2. Review of the facilities timeline of events from their own video footage included the following: a. 7:36:41 p.m. - The nurse walked to Resident #4 positioned in the dining room and completed a dressing change while the resident's leg rested on a chair directly across the dining/lounge area from Resident #3. During an interview 10/22/25 at a time unknown Staff A confirmed she performed the resident's foot treatment in the dining on 10/17/25. The staff member indicated she had not been aware of the facilities policy and procedure related treatments and privacy. Staff A signed acknowledgement of the facilities LPN Floor Nurse job description form on 5/12/25 which indicated she understood her job duties which included the following: a. Promotion of quality nurse care to guests in an environment that promoted their rights, dignity and freedom of choice. b. Maintained the comfort, privacy and dignity of guest and interacted with them in a manner that displayed warmth, respect and promoted a caring environment. The facilities Resident Rights - Dignity and Respect form revised 4.2024 indicated the Purpose as the foundation for the treatment of all residents with dignity and respect. The Procedure included the following: a. Each resident had the right to considerate and respectful care and to have been treated with honesty, dignity, respect and with reasonable accommodation of individual needs. b. Each resident had the right to have been free from physical, verbal, sexual or mental abuse.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, staff interview, family interview, hospital staff interview and facility policy review the facility failed to notify 1 of 3 resident family members/representatives which pertained to a condition change and/or medication error. (Resident #3) The facility identified a census of 42 residents. Findings include: A Progress Note entry identified as a late entry for the following event dated 10/17/25 at 7 p. m. included the following information: Resident #3 had been administered the medications for Resident #6 which consisted of Melatonin (hormone that regulated sleep) 3 milligrams (mgs), Mirtazapine (antidepressant) 15 mg, Alprazolam (antianxiety) 0.375 mgs and Apixaban (anticoagulant) 2.5 mg. Staff A, Licensed Practical Nurse (LPN) asked the emergency room (ED) Physician Assistant to have notified the family. The facility notified the family on 10.20.25 at 4:30 p.m. During an interview on 10/21/25 at 1:50 p.m. the resident's family indicated just prior to her fall the resident received four (4) wrong medications, Mirtazapine, Alprazolam, Melatonin and Eliquis prescribed for a separate resident and the facility failed to notify the family. The family indicated they were alerted to the mistake on 10/20/25 when they received the hospitals History and Physical report but the facility failed to notify them directly. The family indicated the facility only told the hospital she received Eliquis that was not prescribed to her on 10/17/25 but not the other 3 medications.Staff A signed acknowledgement of the facilities LPN Floor Nurse job description form on 5/12/25 which indicated she understood her job duties which included the following: a. Promotion of quality nurse care to guests in an environment that promoted their rights, dignity and freedom of choice. b. Responsible for all nursing care of assigned guest while on duty. Notification of appropriate persons of a significant change in a guest's condition. A Notification for Change of Condition policy and procedure form revised 6.2023 indicated the Purpose as a provision of care to residents and notification of resident change in status. The Procedure included the following: a. Immediately informed the resident, consult with the resident's physician and if known, notification of the resident's legal representative or an interested family member when there had been the following: 1. An accident which involved the resident which resulted in injury with a potential for physician intervention. 2. A significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental or physical status).

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, staff email and a Skin Quick Reference form, the facility staff failed to maintain complete and accurate Care Plans for 1 of 3 residents reviewed. (Resident #8) The facility identified a census of 45 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 9/22/25, (follow up to his 9/15/25 readmission to the facility) indicated Resident #8 had diagnosis that included Heart Failure (HF), Diabetes Mellitus (DM), Non-Alzheimer's Dementia, altered mental status, adult failure to thrive and abnormal weight loss. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 (cognitively intact), required partial/moderate assistance with toileting, personal hygiene and non-ambulatory. The assessment identified the resident without any skin issues and as not on a repositioning program. A Nursing - Admission/readmission Assessment form dated 9/15/25 at 12:39 p.m. indicated the resident as readmitted to the facility with a right trochanter blister and a scabbed area on his coccyx and no further assessment provided (i.e. measurements, surrounding skin, drainage, odor). The form indicated the resident had a history of pressure ulcers and at risk for further development of ulcers. The Care Plan failed to address the resident's active skin issues and expected interventions. According to an email dated 11/14/25 at 2:40 p.m. the Director of Nursing (DON) sent the following explanation which pertained to the Care Plan policy: Per the Care Plan Policy - The facility puts in place person centered care plans outlining care for residents. These are reviewed and revised by the interdisciplinary team after completion of MDS assessments, when applicable and with changes that warrant a care plan revision.Review of a Skin Quick Reference Guide revised 11/2023 provided by the facility included the following Components of a Wound Evaluation:a. A completed head to toe body assessment upon admission and a confirmed re-check within 24 hours of admission. b. Completed documentation required as noted above. c. Initiated Care Plan interventions.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Based on clinical record review, staff interview, facility video, and facility policy review the facility failed to properly assess and intervene for 2 of 3 residents reviewed, (Residents #3 and #8). The facility identified a census of 45 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 7/24/25 indicated Resident #3 had diagnosis that included Non-Traumatic Brain Dysfunction, Alzheimer's Disease, Non-Alzheimer's Dementia and a Retinal Vascular Occlusion. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 (cognitively impaired), with delusions, ambulated with a walker, required supervision to touch assistance with transfers and ambulation and with two (2) falls since reentry to the facility on 2/25/25. A Care Plan included the following Focus and Interventions: a. I have impaired visual function related to (r/t) blindness in my right eye. b. The resident required assistance with activities of daily living (ADL's). 1. Ambulation - Supervision with assistance of one (1) staff member. c. At risk for falls. 1. Resident fell 2/21/25, 2/23/25, 7/9/25, 7/22/25, 8/26/25 and 10/17/25. d. At risk for pain r/t generalized pain verbalized by the resident. 1. Evaluation of her pain level as ordered. 2. Monitored for factors/activities that precipitated or aggravated the pain. e. Resident required an indwelling catheter. Review of the facilities video footage revealed the following instances occurred on 10/17/25 at the approximate times listed below: a. At 7:31:52 until 7:32:04 p.m. (according to the video time stamp) - The resident stood from her recliner took five (5) steps towards a dining room table, tripped over her catheter tubing, fell on her left side and hit her head on the recliner all the while Staff A, Licensed Practical Nurse (LPN) and Staff B, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) stood at the nurse's station. b. 7:31:59 p. m. - Staff A remained at the nurse's station while Staff B walked around the front of the station with her head positioned down as she looked at an item in her and and walked down the North hallway. The resident in site. c. 7:32:08 p.m. - The resident stood from the reclined electric chair d. 7:32:13 thru 7:32:23 p.m. - Staff A casually walked to the resident positioned on the floor and held out her hand towards the resident. e. 7:32:31 - Staff B arrived and both Staff A and Staff B sat the resident up on her buttocks. f. 7:33:13 - Both staff members placed their hands/arms under the resident's bilateral arms/axilla (armpit) area and stood the resident while her left leg presented internally rotated, her foot dragged behind and she refused application of pressure to the area. g. 7:33:31 - The staff sat the resident in a dining room chair. h. 7:33:38 - Staff B pushed the dining room chair across the carpet approximately 10 feet to the same electric recliner she stood from prior. i. 7:34:08 - Staff again transferred the resident as described above from the dining room chair to an electric recliner. j. 7:34:19 - The resident held her left leg/hip while positioned in her chair. k. 7:34:30 thru 7:35:25 - Staff covered the resident with a blanket, reclined the chair and walked away. l. 8:43:54 p.m. - Staff A and Staff C, CNA stood resident from recliner chair without the use of a gait belt assistive device and ambulated the resident attempted to take approximately 10 steps to a dining room table, limped during the process and failed to bare weight on the left leg. m. 8:45:09 p.m. - The resident remained in a standing position at the dining room table as she leaned her head down (chin to chest type position) and rested her arms on the table. n. 8:45:27 p.m. - The resident stood back up straight. o. 8:46:03 p.m. - The resident remained standing but leaned to the left and on Staff A. p. 8:46:29 p.m. - Staff A assisted the resident into a dining room chair. q. 8:47:04 p.m. - Staff C brought a piece of paper and writing tool to the resident as a means of communication. r. 8:53:05 - The resident remained positioned in the dining room chair as she moved around frequently as Staff A and C periodically stayed and left the resident's side. s. 8:55:54 - Staff A and Staff C stood the resident as stated above and again without the use of a GB assistive device. t. 8:56:11 - The staff sat the resident back down in the dining room chair. u. 9:21:25 - The ambulance crew arrived. v. 9:27:25 - Transferred the resident per GB and the assistance of 2 ambulance crew members. A Progress Note entry identified as a late entry dated 10/17/25 at 7 p.m. included the following information: Resident #3 had been administered the medications for Resident #6 which consisted of Melatonin (hormone that regulated sleep) 3 milligrams (mgs), Mirtazapine (antidepressant) 15 mg, Alprazolam (antianxiety) 0.375 mgs and Apixaban (anticoagulant) 2.5 mg. A Progress Note entry identified an Incident Report as a late entry dated 10/17/25 at 7 p.m. included the following information: The resident sat in a recliner in the day room, stood up and immediately fell to the floor next to the recliner. The nurse witnessed the fall from across the room and observed her as she landed on her left side on the floor while the pressure alarm sounded. Staff assisted the resident to her feet and helped her back into the recliner. The resident complained of pain to her left leg with no deformity noted and no pain as the nurse palpated the upper leg. Vital signs included a blood

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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** Based on staff interview, resident interview and facility policy review the facility failed to answer resident call lights in a timely manner, within 15 minutes and provide enough staff to meet the individual needs of the residents for 2 of 2 residents reviewed. (Resident #2 and #4) The facility identified a census of 45 residents. Findings include: During an interview on 10/28/25 at 11:03 a.m. Resident #2 offered she felt the facility failed to staff the appropriate amount of staff to meet the individual needs of the residents. The resident indicated she timed her call light as on for 2 1/2 hours as she used the clock on the wall which caused her anger. The resident also offered recently staff left her in bed in the morning because it took 2-3 staff for transfers and the facility failed to provide enough staff to get her up for the day that morning which she wanted to do. During an interview on 10/28/25 at 1:06 p.m. Resident #4 confirmed she waited for an extended period of time for staff to have responded to her call light and no time of day had been worse than the other. During an interview on 10/29/25 at 1:59 p.m. Staff F, Certified Nursing Assistant (CNA) confirmed staff as unable to answer resident call lights within 15 minutes because they got stuck in resident rooms somewhere and there had been no way to get to resident's fast enough. The staff member felt the facility failed to provide enough staff because she felt people had not wanted to work healthcare. The current healthcare staffing crisis had been contributed to the fact the care in nursing facilities had not been like the [NAME] days, its not grandma's and grandpa's anymore it had been so many more types of residents they cared for now. During an interview on 10/29/25 at 2:08 p.m. Staff G, CNA indicated staff answered resident call lights 95% of the time but felt the staff had been staffing challenged the past year because of management having capped staff wages which made Staff G sad. During an interview on 10/29/25 at 2:49 p.m. Staff I, CNA indicated staff tried to answer resident call lights within 15 minutes but she could not confirm it occurred every single time. A Call Light Policy form revised 9/2023 described the Purpose as an assurance of prompt responses to a resident's call for assistance.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on the facilities video footage review, clinical record review and staff interview the facility failed to assure 2 of 3 residents remained free of significant medication errors. (Resident #3 and #5)Findings include: The facilities Investigative Report form included the following timeline of events per their review of the video footage: a. 7:10:25 p.m. (camera time) - Staff B, Certified Medication Aide (CMA) administered the physician prescribed medications for Resident #3. b. 7:30:06 p.m. - The CMA wrongfully administered medications prescribed for Resident #6 to Resident #3. According to a computer generated form the CMA administered the following medications prescribed to Resident #3 on 10/17/25 at 6:21 p.m. a. Buspirone Hydrochloride (anti-anxiety) 5 milligram (mg) tablet. b. Acetaminophen (pain) 325 mg tablet. c. Alprazolam/Xanax (anti-anxiety) 0.25 mg tablet. d. Melatonin (sedative/hypnotics) 5 mg tablet. e. Pepcid (H2-receptor (decreases acid in the stomach) 20 mg tablet.According to a Medication Event - Wrong Medication form dated 10/17/25 at 7 p.m. Staff A, Licensed Practical Nurse (LPN) documented Staff B had been in the middle of her medication pass and just answered a telephone call amidst other interruptions when a resident's pressure alarm went off. The CMA rushed to assist the resident back into her recliner because she scooted herself to the edge of the recliner and tried to stand up. The CMA had another resident's medications crushed in a cup with a spoon during that time and erroneously gave this resident Melatonin 3 mgs, Mirtazapine (anti-depressant) 15 mg, Alprazolam 0.75 mgs and Apixaban (anti-coagulant) 2.5 mg. According to a written statement (not dated) the Director of Nursing (DON) confirmed Resident #3 received the medications prescribed for Resident #6 at approximately 6:36 p.m.2. An Incident Report-Medication Event form dated 9/10/25 at 4:28 p.m. included the following information: Staff discovered on rounds that Resident #5 continued to receive Seroquel 12.5 mgs in addition to Seroquel 25 mg in the morning when the Physician changed the order on 8/28/25 for Seroquel 25 mgs in the morning and 12.5 mg at noon and supper.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review, staff interview, a Licensed Practical Nurse (LPN) Job Description form and facility policy review, the facility failed to maintain complete and accurate resident records for 2 of 3 residents reviewed. (Resident #3 and #5) The facility identified a census of 45 residents.Findings include: A Progress Note entry identified an Incident Report as a (late entry) dated 10/17/25 at 7 p.m. included the following information: The resident sat in a recliner in the day room, stood up and immediately fell to the floor next to the recliner. The nurse witnessed the fall from across the room and observed her as she landed on her left side on the floor while the pressure alarm sounded. Staff assisted the resident to her feet and helped her back into the recliner. The resident complained of pain to her left leg with no deformity noted and no pain as the nurse palpated the upper leg. Vital signs included a blood pressure (B/P) of 156/80, Pulse (P) 83, Respirations (R) 20, Temperature (T) 97.2 degrees Fahrenheit (F) and an oxygen saturation rate (O2) of 95%. The resident continued to complain of leg pain so Staff A and Staff B, CNA stood the resident and walked her as the resident refused placement of weight on her left leg. Staff sent the resident to the emergency room (ED) by ambulance. An X-ray showed a closed, traumatic, minimally displaced fracture of the trochanter of the left femur. The family chose no surgical intervention and the hospital sent the resident back to the facility on Hospice care. According to an email dated 10/31/25 at 11:12 a.m. the Director of Nursing (DON) indicated Staff A documented the above stated information on 10/20/25 at a time unknown and under the directive of management. Review of the facilities video footage dated 10/17/25 from 7:31:52 thru 9:27:25 revealed Staff A failed to assess the resident while positioned on the floor which included any physical abnormalities and vital signs. Staff A and Staff B stood the resident while her left foot leg appeared internally rotated and the resident failed to place any pressure on the foot/leg. According to an email dated 10/31/25 at 12:02 p.m. the DON indicated she had not been sure where Staff A obtained the information she documented above because during their interview process Staff A had been unable to answer questions that pertained to her assessment as she told the DON she could not have recalled. A Fall Occurrence policy revised 2/2024 included the following Procedures: a. An incident report completed by the nurse each time a resident fell.b. Residents assessed by a licensed nurse prior to having been moved after a fall.c. Neurological assessment initiated when a resident hit their head. 2. An Individual Resident's Controlled Substance Record form dated 9/29/25 indicated Resident #6 had a physician's order for Xanax 0.25 milligrams (mgs)1.5 tablets and on 10/17/25 at 6:36 p.m. the medication had been destroyed. During an interview 10/23/25 at approximately 1 p.m. the Director of Nursing (DON) confirmed the medication as not destroyed rather administered to Resident #3. Staff A signed acknowledgement of the facilities LPN Floor Nurse job description form on 5/12/25 which indicated she understood her job duties which included the following: a. Promotion of quality nurse care to guests in an environment that promoted their rights, dignity and freedom of choice. b. Carried out direct contemporaneous charting on your shift. c. Completed medical records documenting care provided and other information in accordance with nursing policies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, facility video review, resident interview, staff interview and facility policy review, the facility failed to follow appropriate infection control practices during direct resident cares for 3 of 3 residents reviewed. (Resident #1, #3 and #4) The facility identified a census of 45 residents.Findings includeAn observation of the facilities video coverage dated 10/17/25 revealed Staff J, Licensed Practical Nurse (LPN) as she washed and gloved her hands prior to the removal of a supportive boot and wound dressing on the left foot/leg of Resident #4. The staff member then performed the prescribed physician treatment to the resident's upper left heel and the tips of her toes with the same gloved hands. Following completion of the treatment Staff J placed the non-used and/or prescribed treatment supplies in a plastic bag and placed the plastic bag back into the resident's treatment supply basin without sanitization of the surface areas. During an interview on 10/28/25 at 4:20 p.m. the Director of Nursing (DON) confirmed the above documented observation. Review of the facilities video footage dated 10/17/25 revealed the following as timed: a. 7:36:40 p.m. - Staff A, performed the treatment to the left leg/foot of Resident #1 in the dining/lounge public area with six (6) residents present. The staff member failed to place a barrier between the table and resident treatment supplies that consisted of creams, bandages, scissors, tape and etc. Following completion of the treatment the staff member placed the remaining supplies directly into the treatment cart without sanitization. b. 8:26:17 p.m. - As Resident #3 remained positioned in a recliner in the dining/lounge area, Staff A approached her, pulled out the resident's sweat pants as she palpated the residents left hip with her bare hands and proceeded to touch the resident's person, the furnishings and herself without having washed her hands. Review of the facilities video footage timeline of events revealed the following; a. 7:26:41 thru 7:48:31 - Staff A walked to Resident #1 in the dining area and completed the dressing change while her leg had been positioned on a chair directly across the dining area from Resident #3. b. 7:49:40 p.m. - Staff A pressed on the resident's left hip area. c. 7:50:34 p.m. The nurse looked under the residents pajama bottoms as if she looked for any bruising or injury and pressed on the resident's hip. d. 7:51:30 p.m. - The nurse finished with the resident and walked away. e. 7:52:42 p.m. - The nurse walked back to the resident after she applied gloves at the medication cart and again palpated or rubbed the resident's left hip. During an interview on 10/22/25 Staff A confirmed she failed to place a barrier between the table and treatment supplies and she failed to sanitize the items when she replaced them into the treatment cart.