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	03/04/2026

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

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff, doctor, pharmacist interview, and policy review the facility failed to have 4 of 7 nurses administer medications following the 6 rights of medication administration. The 6 rights are a process of verifying the right resident, right drug, right dose, right route, right time, and right documentation performed to systematically minimize medication errors, ensure patient safety, and maintain the efficacy of treatment. By verifying these key factors, healthcare providers prevent adverse events, protect residents, and adhere to safety protocols. Staff A, Licensed Practical Nurse (LPN), Staff B, LPN, Staff F, Registered Nurse (RN), and Staff G, LPN administered medications for residents who resided in the facility on the morning of 2/22/26 and morning of 2/27/26 without following the proper medication administration procedures by administering medications which were pre-set (set up in advance of being administered). The residents' medications included insulin, blood pressure, and anticoagulant (blood thinning) medications. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents who resided at the facility as it was seriously likely receiving the wrong dose of insulin and/or medications could result in life-threatening complications. The facility also failed to prime an insulin pen for 1 of 1 resident prior to giving (Resident #43). The facility reported a census of 44 residents.The State Agency informed the facility of the Immediate Jeopardy (IJ) on 2/22/26 at 11:50 AM. The IJ began on 2/22/26, the day the first observation was made of staff not following the 6 Rights of Medication Administration.Facility staff removed the Immediate Jeopardy on 2/22/26 through the following actions:1. Pre-poured medications were immediately destroyed and disposed of appropriately. Destroyed medications will be reimbursed to the residents.2. Nurses and Certified Medication Aides (CMA) education initiated on 2/22/26 prior to working the next shift on medication administration and the 6 Rights of Medication Administration.3. Facility staff who administered medications including professional nurses and CMA's were educated on 2/22/2026 regarding passing medications that only that nurse or CMA has prepared themselves.Initially, the immediacy of the IJ was removed on 2/22/26 at 5:06 PM after verification all staff had received and acknowledged the training.However, on 3/2/26 at 4:57 PM the facility was notified the removal of IJ immediacy was rescinded due to an observation of ongoing failure occurring on 2/27/26. Video footage and staff interviews revealed nurses continued to not follow proper medication administration procedures (Staff F, RN and Staff G, LPN). Facility staff completed additional education and officially removed the Immediate Jeopardy on 3/3/26 through the following actions:1. On 3/2/26 re-education was completed with staff who pass medication regarding preparing medications at time of administration and reviewing the 6 Rights of Medication Administration.2. Administrative oversight remains in place and will continue to ensure understanding of medication administration process is followed.3. Facility staff who pass medications will complete medication administration competencies with direct in person oversight on 3/3/26. Any staff who are not available will complete medication administration competencies prior to next scheduled shift.4. All nursing staff will sign the Acknowledgment and Agreement of Proper Medication Pass Practice, including disciplinary action as indicated in the agreement.5. Daily random audits of medication administration will be completed.The immediacy of (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	the IJ was removed on 3/3/26 at 4:21 PM after verification all staff received the training and had completed or were scheduled to complete the in person training prior to their next scheduled shift.The deficient practice was identified on 2/22/26 and the scope lowered from L to F on 3/3/26 after the facility implemented additional education and in person training. Findings include: 1. Observation on 2/22/26 at 7:17 AM revealed the facility had two (2) medication carts (South cart and North cart) in the building that contained all residents oral daily medications. The top drawer of the South medication cart contained 21 plastic med cups with pills placed inside them and white paper med cups placed on top of the pills with names written on the paper. The top drawer of the North cart also had 18 plastic med cups with medications inside them and white paper med cups with names written on them. Observation revealed 6 insulin pens with attached needles in an unlocked container that sat at the nurse's station pre-dialed to dosage amount. Three more insulin pens sat in the same container not dialed up without insulin needles on. On 2/22/26 at 7:25 AM, Staff B, Licensed Practical Nurse (LPN), stated she was the Charge Nurse on shift that day and she worked for a staffing agency. She revealed she started setting up all the residents' medications on the South medication cart around 5:00 AM for that day's morning medication pass. She revealed setting up resident medications ahead of time was just something they did at this facility and she did not do this at any other nursing home. On 2/22/26 at 9:53 AM, Staff A, LPN, stated she normally worked afternoons and dayshift not her normal shift. She said when she came in that morning all her residents' morning medications were set up on the North medication cart for her for the morning medication pass and she did not set them up herself. Staff A revealed she verified if the medications were correct when she checked the name written on the white paper medication cup on top and compared it with the Medication Administration Record (MAR), but she did not know for sure what meds were in the cup she passed. She verbalized she should have set up the medications at the time she was going to give them to a resident, she would notify the Director of Nursing (DON) in the future if another nurse set up her meds, she destroyed the meds in the drug buster (system designed to safely deactivate and dispose of medications), and she would not administer medications again that another nurse set up. Staff A said when the DON came in she directed her to destroy all the pre set up medications that were observed in the medication cart (18 residents morning medications) into the drug buster. In a follow up interview with Staff B, LPN, on 2/22/26 at 11:10 AM, she explained she worked at this facility 1-2 shifts a week and she came in at 4:00 AM. Staff B said she started setting up the residents' morning pills around 5:00 AM. Staff B revealed she was trained to prepare meds this way at this facility so they were able to take the medications with the morning breakfast trays or help with transfers and pretty much all the nurses pre-set up medications. Staff B stated if residents received narcotics she would retrieve them at the time she was going to give the resident their pills. Staff explained she did not normally check blister packs (pharmacy packing with each pill enclosed separately - used for secure, organized, tamper-evident packaging of medications which enhances medication adherence by organizing doses, prevent double-dosing, and allow for easy, visible monitoring), instead she would grab the medications she set up earlier with the residents name on it and go to give them. Staff B explained it was quicker but she knew she was not supposed to do it that way. Staff B reported the night charge nurse Staff C, RN, set up Staff A's residents' medications which she gave that morning for her to administer to the residents, and all the insulins on the North and South medication carts that were to be given in the morning, prior to her coming in at 4:00 AM. Staff B said it was just how they did it in the morning and she knew setting up medications was not allowed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 2/24/26 at 11:17 AM, Staff C, RN, reported on 2/22/26 around 2:30 AM to 3:00 AM, she set up all residents' morning medications on the North med cart for Staff A, LPN, to pass and it included maybe around 20 residents' morning medications and one narcotic of Lyrica (a controlled substance used to treat pain). Staff C stated she looked at each medication when she was setting them up and went right on down the line. She revealed she put the meds in a plastic med cup with a white paper med cup on top and wrote the resident's name on them. Staff C said if more than one resident went by the same name she would put their last name initial on it. She revealed she did it because she thought they were going to be short a person so she thought she would help. Staff C reported she also set up all the insulin pens for Staff B, LPN, and Staff B was supposed to double check them before giving, and Staff C put the insulin pens all in one container. Staff C stated she primed the pens prior to dialing up the dosage and left them in the medication room sitting in the container for Staff B to give so she could have a jump start. Staff C revealed she did not usually do that and only did it because she thought they were going to be short staffed. Staff C said Staff A, LPN, did not ask her to set up the medications and she did not talk to Staff A to tell her what she did prior to leaving the facility. Staff C said she thought Staff A could verify by counting to make sure she had the right number of pills in the cup so this practice would have made it faster for Staff A. Staff C revealed she did not normally pass medications on her scheduled shift (overnight shift). Staff C verbalized the facility educated her on the 6 Rights of Medication Administration, the facility policy, and they were not to be setting up medications in advance. On 3/3/26 at 3:15 PM, the DON reported on 2/22/26 when she arrived to the facility, Staff B, LPN, told her the medications were set up and the State took pictures and looked at the med carts. The DON said she told Staff A, LPN, to not give any more medications that Staff C had set up for her and to destroy the meds in the drug buster. On 2/25/26 the facility provided an undated list titled, Morning Insulin, that listed the residents whose insulin pens were observed in the container together on 2/22/26 at 7:18 AM; Resident #30, #14, #43, #19, #2, and #4. Review of February Medication Administration Records (MAR) for Resident #30, #14, #43, #19, #2, and #4 revealed the following morning insulin orders: a. Resident #30 long acting insulin 16 units dailyb. Resident #14 long acting insulin 35 units daily and^ rapid acting insulin 0 - 18 units with meals depending on the blood sugar reading at the timec. Resident #43 rapid acting insulin 15 units daily and 0-7 units with meals depending on the blood sugar reading at the time. d. Resident #19 long acting insulin 30 units and rapid acting insulin 7 unitse. Resident #2 rapid acting insulin 7 units daily^f. Resident #4 long acting insulin 38 units twice a day Review of an Order Listing Report provided by the facility on 2/22/26 revealed 25 residents received blood pressure medications the morning of 2/22/26. Review of an Order Listing Report provided by the facility on 2/22/26 revealed 22 residents received anticoagulant medications the morning of 2/22/26. Review of the February 2026 Medication Administration Records (MARs) for all residents in the facility (44 residents) revealed each individual resident's MAR documented they received all morning medications during the morning medication pass on 2/22/26. The Resident Listing Report dated 2/25/26 documented 5 residents in the facility had the same first (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	name (Resident #2, #12, #20, #21, and #25). The document revealed Resident #20 and #21 also had the same first initial of their last name. Review of the February 2026 MARs for these residents revealed the following: a. Resident #2's February 2026 MAR revealed he took, in part, the following types of medication during the morning medication pass on 2/22/26: insulin, antihyperglycemic (diabetic medication to lower blood sugar), diuretics (water pill, gets ride of excess sodium and water), antifungal (antimicrobials used to treat and prevent infections), beta-blocker (lowers blood pressure), anticoagulant (blood thinner), potassium (supplement), non-ergoline dopamine agonists (used to treat restless leg syndrome), laxative, magnesium (supplement), and an antidepressant. b. Resident #12's February 2026 MAR revealed he took, in part, the following types of medication during the morning mediation pass on 2/22/26: gabapentinoid and anticonvulsant (controlled substance used for nerve pain), stool softener, antidepressant, angiotensin-converting enzyme (ACE) inhibitor (lowers blood pressure), cholinesterase inhibitors (for dementia), cholesterol absorption inhibitors (lowers bad cholesterol), laxative, alpha-1 adrenergic blockers (helps urine to flow more easily), anticonvulsant and mood-stabilizer (used to treat seizures, bipolar, and migraine prevention), and antipsychotic (primarily used to manage psychosis, including hallucinations, delusions, and schizophrenia). c. Resident #20's February 2026 MAR revealed he took the following types of medication during the morning mediation pass on 2/22/26: thiazide diuretic (used to treat high blood pressure and fluid retentions), ACE Inhibitor, non-opioid analgesic (pain reliever) and antipyretic (fever reducer), nonsteroidal anti-inflammatory drug (NSAID) (used to treat pain, fever, and inflammation), and anorectic (controlled substance for appetite suppression). d. Resident #21's February 2026 MAR revealed he took, in part, the following types of medication during the morning mediation pass on 2/22/26: antidepressant, antiplatelet (used to prevent blood clots), diabetic oral medications, opioid analgesic (controlled substance, narcotic), antihyperglycemic, proton pump inhibitor (reduces stomach acid), beta-blocker, antipsychotic, non-opioid analgesic, and anticonvulsant. e. Resident #25's February 2026 MAR revealed he took the following types of medication during the morning mediation pass on 2/22/26: Vitamin D (supplement), anticoagulant, and stool softener. On 2/22/26 at 11:26 AM, the DON reported all staff had been educated on not pre-setting up medications, she had completed audits on it in the past, and there hadn't been any issues. The DON revealed she instructed Staff A that morning to put the already set up medications in the drug buster. The DON reported Staff C had been educated in the past to not set up medications, and the DON thought it had been taken care of and that nurses were not presetting up medications anymore. The DON stated she felt the nurses had plenty of time to pass medications the correct way and she was not sure why they were presetting them up; it was not how they were trained. On 2/22/26 at 4:19 PM, the Administrator and DON reported they spoke with Staff C, RN, and Staff C confirmed she did set up all of Staff A's residents' morning medications for Staff A to pass on 2/22/26 because she was just trying to be helpful. The DON stated she instructed Staff C that could not be done. The Administrator and DON stated they provided education that day to all staff who pass medications in the facility, including agency staff, that they should only provide medications that they prepared themselves, only set up 1 resident's medication at a time, and medications should not be set (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	up ahead of time for any reason. They reported everyone had acknowledge of the training and the importance of it. The Administrator and DON said they reviewed with the nurses the facility's Medication Administration - Medication Pass policy, last revised 5/2023, which contained the 6 Rights of Medication Administration and that they expected the policy to be followed that included: The right resident with 2 resident identifiers. The right medication, if its a stock medication or a blister pack (pharmacy packaging used as a tamper-evident method for storing medication using small plastic bubbles (blisters) with a foil or paper backing. Each dose is sealed in its own compartment). The right dosage of the medication by comparing the Medication Administration Record (MAR) and the medication label on the card. The right time and frequency of the medication. The right route (way to take the medication, such as by mouth or by an injection). Documentation after administering the medication. On 2/22/26 at 4:39 PM, Staff D, Certified Medication Assistant (CMA), confirmed she had been educated on not setting up medications and to follow the 6 Rights of Medication Administration and the facility's policy prior to her scheduled shift that day. On 2/22/26 at 4:55 PM, Staff J, LPN, confirmed she had been educated on the 6 Rights of Medication Administration and she was not to set up medications. Staff J revealed she heard nurses on the morning shift would pre-set up medications, but she had never observed it. 2. Observation with the Administrator on 3/2/26 at 1:23 PM to 1:55 PM of facility camera footage revealed on 2/27/26 from 5:35 AM to approximately 5:55 AM, Staff F, RN, and Staff G, LPN, stood at the North and South medication carts frequently opening drawers and it appeared the nurses were setting up morning medications for residents. On 3/2/26 at 2:02 PM, Staff H, Certified Nurse Aide (CNA), revealed on 2/27/26 she came to the facility for her morning shift around 5:45 AM and saw Staff F and Staff G setting up their morning medications. Staff H said she could not believe they were doing exactly what the facility just got in trouble for on 2/22/26. On 3/2/26 at 2:45 PM, Staff F, RN, revealed on 2/27/26 around 5:30 AM she was setting up medication for the North medication cart and it included about 20 residents. Staff F stated she was under the assumption if she set up medications on her cart she could pass those medications, but she knew it's wrong. Staff F revealed she did get education by the facility on 2/22/26, but she assumed if she set up the medication she could still pass them. Staff F said the reason she did that was so she could go in the medication cart and grab the cup that had a paper cup on top with the resident name on it, and deliver it to them. Staff F revealed when she gave the residents their med cup she knew they were getting the right medications because she set them up between 5:00 AM to 5:30 AM. Staff F explained she did this to save time, she just looked for the right name in the medication cart, was able to grab and go by verifying she had the right resident's name on the paper cup, but she did not verify the meds in the cup. Staff F further explained she typically sets up residents' morning (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	medications around 5:30AM to 6:00 AM and residents' noon medications she set up between 9:00 AM to 10:00 AM. Staff F stated after she gave the meds she typically went to the MAR and signed them off, but sometimes she did not get back right away to do that. On 3/2/26 at 3:39 PM, Staff G, LPN, responded she worked the morning of 2/27/26 and did most of the nursing stuff while Staff F, RN, passed most of the medications. Staff G revealed the facility was always short CNAs and so she has to set up morning medications early to be able to get the job done. Staff G stated she set up medications on 2/27/26 for residents by using a plastic cup on bottom to hold the medications and a paper cup on top with the name of the resident the meds were intended for. Staff G said she did not pass any other nurses' medications they set up, but she set up her own meds so she was able to grab the resident's medications and go deliver them. Staff G stated she felt maybe other nurses at the facility could step up and come in to help so they could do it the right way, but she could not get done if she had to actually do it the right way, as she received too many interruptions. Staff G reported she had worked at the facility for 8 years and had always done it that way. In an interview on 3/4/26 at 8:40 AM with the Medical Director for the facility, he indicated he did not do the nurses job so it was hard to judge why the nurses were setting up medications in advance. He also verbalized economics only allows the facility to staff a certain way and if they had more staff then maybe some systems could work better. The Medical Director did not think setting up the insulin was good. He stated the system of setting up medications in advance did kind of bother him, but he was unsure how to help them to have a better solution to make it safe for the residents and meet the expectation with efficiency and not cause something that creates a totally new problem. In an interview on 3/4/26 at 10:07 AM with the Administrator, she stated she did not know why the nurses would be setting up medications in advance, there was a nursing standard of protocol, and the staff knew that it was a standard that should be followed at all times. Per the Administrator, should not be setting up medications early. She further explained it was not the nursing standard of practice from their education program and training and they all knew the right way it should be done. Per the Administrator, there was no excuse for not doing it the right way. She stated she felt it was very clear to them all right now and that it was not acceptable. Per the Administrator, they had all received the education, competency testing, signed contracts, and discipline. The Administrator reported hose that had been involved had received disciplinary action and all staff knew it was not acceptable; never trained or told that it was an acceptable process. In an interview on 3/4/26 at 4:13 PM, the facility's Pharmacist responded RNs and LPNs should administer meds to one patient at a time, punch out the medication, verify the med, and come back to sign them off in the MAR. The Pharmacist stated she would be most worried about anticoagulant medication (medication that thins the blood), as there was a narrow therapeutic window and worried for residents who received blood pressure med if they weren't prescribed any. The Pharmacist commented it was concerning if anyone ever got the wrong medications and it created extra work on the pharmacy end too. She went on to explain all insulin pens should be in the pharmacy labeled packaging, locked up when not used, and insulin should not be pre dialed to the dose until the time of administration. Review of an Order Listing Report provided by the facility on 3/4/26 revealed 12 residents received anticoagulant medications the morning of 2/27/26. Review of an Order Listing Report provided by the facility on 3/4/26 revealed 17 residents received (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	blood pressure medications the morning of 2/27/26. Review of February 2026 MARs for residents who shared the same first name (Resident #2, #12, #20, #21, and #25) revealed the following residents took anticoagulant and/or insulin medication on the morning medication pass on 2/27/26: Resident #2 received insulin and anticoagulant medications. Resident #25 received anticoagulant medication. Review of the facility's policy Medication Administration - Medication Pass, last revised 5/2023 instructed the following: 1. Position medication cart in full view outside patient room or the dining room. 2. Perform hand hygiene. 3. Open Electronic MAR to the residents record and review physician medication orders against medication labels4. Read transcribed physician order on electronic MAR: patient name, medication name, dosage, route and interval ordered, remove medication from cart compare electronic MAR with medication label for accuracy.5. If medication is unfamiliar or physician order is questioned: read original physician order compare original physician order with the electronic MAR for accuracy remove medication from cart and compare with electronic MAR with the medication label for accuracy verify allergy status and contact physician for clarification, if needed 6. Read special medication administration instructions 7. Obtain vital signs, if applicable, and record results on electronic [DATE]. Prepare medications for administration 9. Administer medication, knock on door and request entrance, introduce self, explain medication administration need and provide privacy, administer medication in accordance with frequency prescribed by physician - within 60 minutes before or after prescribed dosing time. lock medication cart when not in direct view of nurse administering medication, take medication(s) and cup of liquid/food, if applicable, to resident, identify resident, describe name of medication and reason for use to patient and answer any questions if needed. Administer medication according to specific procedure such as oral, topical, injection, etc. remain with patient until administration of medication complete and document initials on electronic MAR for each medication administered, if administering a controlled substance it must be documented on controlled substance log and electronic MAR. 10. Patient Refusal, non-controlled medication, dispose of medication appropriately, document refusal on electronic MAR, notify physician/family of refusal as clinically indicated, controlled/narcotic medication refer to individual state regulations on how to dispose of controlled/narcotic medication document refusal on electronic MAR circle initials on Controlled Substance Charting Record and document refusal. Two licensed nurses sign form validating medication destruction notify physician of refusal as clinically indicated 11. Perform hand hygiene 12. Secure cart as required 3. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #43 documented a diagnosis of diabetes mellitus. Observation on 2/22/26 at 9:05 AM revealed Staff B, LPN. turned the dial on the insulin pen to 16 units without priming the insulin needle. Staff B indicated she was ready to administer the insulin (lispro) to Resident #43. After intervening (intervened prior to administration of the insulin due to safety), Staff B indicated she was not aware that she needed to prime the insulin pen needle to clear the needle of air. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff, and pharmacist interviews, and policy review the facility failed to store medications in the pharmacy labeled package for all residents on 2 of 8 days of the survey. The facility also failed to keep insulin pens in a locked container/cart/room and keep narcotic in a double locked container/cart/room. The facility reported a census of 44 residents. Findings include: An observation on 2/22/26 at 7:17 AM revealed the facility had two (2) medication carts (South cart and North cart) in the building that contained all residents oral daily medications. The South cart had 21 plastic cups with pill medications inside them and white paper cups with names written on them, in the top drawer of the cart. The North cart had 18 plastic plastic cups with medications inside them and white paper cups with names written on them, in the top drawer of the cart. There were also 6 insulin pens in an unlocked container sitting at the nurse's station pre-dialed up to dosages with insulin needles on. There were also 3 more insulin pens sitting in the same container not dialed up without insulin needles on. On 2/22/26 at 7:25 AM, Staff B, Licensed Practical Nurse (LPN), stated she was the Charge Nurse on shift that day and she worked for a staffing agency. She revealed she started setting up all the residents' medications on the South medication cart around 5:00 AM for that day's morning medication pass. On 2/22/26 at 9:53 AM, Staff A, LPN stated when she came in that morning all her residents' morning medications were set up on the North medication cart for her for the morning medication pass and she did not set them up herself.On 2/24/26 at 11:17 AM, Staff C, RN, reported on 2/22/26 around 2:30 AM to 3:00 AM, she set up all residents' morning medications on the North med cart for Staff A, LPN, to pass and it included maybe around 20 residents' morning medications and one narcotic of Lyrica (a controlled substance used to treat pain). Staff C stated she looked at each medication when she was setting them up and went right on down the line. She revealed she put the meds in a plastic med cup with a white paper med cup on top and wrote the resident's name on them. On 3/2/26 at 2:45 PM, Staff F, RN, revealed on 2/27/26 around 5:30 AM she was setting up medication for the North medication cart and it included about 20 residents. On 3/2/26 at 3:39 PM, Staff G, LPN, stated she set up medications on 2/27/26 for residents by using a plastic cup on bottom to hold the medications and a paper cup on top with the name of the resident the meds were intended for. In an interview on 3/4/26 at 10:07 AM with the Administrator, she stated she did not know why the nurses would be setting up medications in advance, there was a nursing standard of protocol, and the staff knew that it was a standard that should be followed at all times. In an interview on 3/4/26 at 4:13 PM with the facility's Pharmacist informed RN's and LPN's should do one patient at a time, punch out the medication, verify the med and come back and sign them off. She went on to inform all insulin pens should be in the pharmacy labeled packaging and locked up when not used, and insulin should not be pre dialed to the dose until the time of administration. Review of the facility's policy Medication Administration - Medication Pass, last revised 5/2023 instructed the following:3. Open Electronic MAR (Medication Administration Record) to the residents record and review physician medication orders against medication labels4. Read transcribed physician order on electronic MAR: patient name, medication name, dosage, route and interval ordered, remove medication from cart compare electronic MAR with medication label for accuracy.5. If medication is unfamiliar or physician order is questioned: read original physician order compare original physician order with the electronic MAR for accuracy remove medication from cart and compare with electronic MAR with the medication label for accuracy verify allergy status and contact physician for clarification, if needed.

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	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 record review, staff interview, and policy review the facility failed to make a good faith attempt and ensure effective quality assurance processes regarding significant medication errors when a deficient practice with F760, Residents are Free of Significant Medication Errors, was cited at the facility for 3 of 4 onsite surveys, which included the current survey, since 9/1/2024. The facility reported a census of 44 residents.Findings include: 1.Review of Form CMS-2567 (the official document produced after a state or federal inspection (survey) that included survey results) for the survey ending on 9/22/2024 documented the facility was cited for F760 relating to 1 of 3 residents received 6 medications that were not prescribed for him and was hospitalized overnight for observation. 2. Review of Form CMS-2567 for the survey ending on 11/14/2025 documented the facility was cited for F760 relating for 2 of 3 residents who had significant medication errors. One resident received 5 medications that were not prescribed to them and another resident continued to receive medication that was discontinued. A deficient practice with F760 was identified on the current survey ending on 3/4/2026. ˆIn an interview on 3/4/26 at 10:07 AM with the Administrator explained the facility completed plans of correction on F760 tags prior and did audits, she explained the DON (Director of Nursing) worked the floor, and they did not find any cause for concerns from those audits. Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan dated 10/3/25 instructed the following for recognizing problems and improvement opportunities: The QAPI plan address the element of systematic analysis and systemic action using the following processes and system: root cause analysis, use of continuous cycle to evaluate the effectiveness of he performance improvement initiatives, communication of performance improvement project efforts and re-evaluation of the center's QAPI plan annually. The Direction of QAPI Activities section of the Plan included the QAPI committee was responsible and accountable for ensuring corrective actions were effective.

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	165338	A. Building B. Wing	03/04/2026

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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, staff interviews, and policy review the facility failed to implement infection control measures when 6 of 6 morning insulins were stored together in a container (Resident #30, #14, #43, #19, #2, and #4). The facility also failed to provide Enhanced Barrier Precautions (EBP) as the Centers for Disease Control and Prevention (CDC) (an infection control strategy for nursing homes and long-term care facilities to reduce the spread of multidrug-resistant organisms, It involves using gowns and gloves during high-contact care for residents with wounds, indwelling devices, or known multi-drug resistant organism colonization) directs during wound care (Resident #37). The facility also failed complete routine glove change and hand hygiene during pressure ulcer care after cleaning the wound for 1 of 1 residents (Resident #37). The facility reported a census of 44 residents. Findings include: 1. An observation on 2/22/26 at 7:18 AM at the nurses station revealed 6 insulin pens were being stored with their lids off and touching in a plastic unlocked container with a blood glucose machine. In an interview with Staff B, Licensed Practical Nurse (LPN) on 2/22/26 at 11:10 AM revealed she came in at 4:00 AM today and Staff C, Registered Nurse (RN) had already pre dialed up her insulin medications for her and placed them in a container together for her to give. She acknowledged they should have been locked up and stored separately and not touching. In an interview on 2/22/26 at 11:26 AM with the Director of Nursing (DON) informed the staff have been educated on not setting up medications in the past and she is not sure why they do it, and it was not how they were trained. In an interview with Staff C, Registered Nurse (RN) on 2/24/26 at 11:17 AM revealed she pre dialed six (6) insulin pens for Staff B on 2/22/26 around 2:00 AM to 2:30 AM and put them in the medication room sitting together in a plastic container. She informed she did this to help give Staff B a jump start when she would arrive to the facility. During an interview on 2/25/2026 at 1:06 PM the Infection Preventionist explained each resident's insulin pens should be stored in separate containers within the medication cart. The facility provided on 2/25/26 a undated list titled, Morning Insulins, for residents whose insulin pens were observed in the container together on 2/22/26 at 7:18 AM; Resident #30, #14, #43, #19, #2, and #4. Review of the facility's policy Medication Administration - Medication Pass, last revised 5/2023, instructed to remove medication from the locked medication cart, listed multiple steps on how to ensure verification of the medication and then to administer. 2. Resident #37's 11/20/25 Minimum Data Set (MDS) Assessment showed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The MDS lacked documentation of pressure wounds to the heels. The MDS documented other open lesions on the foot; use of a pressure reducing device for the chair and the bed, nutritional intervention to manage skin problems, and application of dressing to the feet. A Physician Order signed by the Provider on 2/4/26 directed to apply a hillbilly hyperbaric (oxygen treatment to the pressure wound) to the left heel pressure ulcer wound for 2 hours twice a day. Apply a dressing change twice a day and as needed. Cleanse the pressure wound with hydrogen peroxide, (continued on next page)

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	165338	A. Building B. Wing	03/04/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	light gauze over the wound when not in oxygen (treatment). The 12/2/25 Risk of Alteration in Skin Integrity Care Plan documented stage 4 pressure ulcers to both the right and left heels and directed the nursing staff to administer the treatment per the physician orders. The Care Plan lacked direction to utilize EBP due to pressure wounds of both heels. Observations on 2/25/26 at 8:48 AM revealed no CDC EBP sign on Resident #37's door. During an observation completed on 2/25/26 at 8:49 AM, Staff E, Licensed Practical Nurse (LPN) knocked, explained, washed hands and provided privacy. Staff E failed to apply a gown for EBP prior to initiating the wound treatment. Staff E opened a new package of oxygen tubing, attached the tubing to the oxygen concentrator and placed the tubing inside a plastic bag. Staff E then applied gloves without performing hand hygiene, removed Resident #37's left sock and gauze dressing to the left heel. Staff E changed her gloves without performing hand hygiene, placed a clean paper chux under left heel. Staff E proceeded to cleanse the left heel pressure wound, then changed her gloves without performing hand hygiene. Observation revealed a oblong triangular open wound bed to the left heel with an approximate quarter size of serosanguineous drainage to the old wound dressing. Staff E applied the plastic bag over Resident #37's left calf, secured the bag in place with tape, removed her gloves, turned on the oxygen concentrator and then placed another clean chux under Resident #37's left foot. Staff E washed her hands and turned the faucet off with her right wrist, then dried her hands with paper towel. During an observation on 2/25/26 at 11:11 AM Staff E applied gloves, removed the tape and plastic bag (hillbilly bariatric chamber device) from the resident's left foot. Staff E changed gloves without performing hand hygiene and placed a clean paper chux under the resident's left heel. Staff E cleansed Resident #37's left heel, then applied a clean gauze dressing without changing gloves and secured the dressing with tape. She removed the paper chux from under the resident's left heel. Removed her gloves. Staff E pulled the garbage up out of the garbage can, tied the garbage bag, then picked up Resident #37's clean sock from the bedside table and placed his sock on the left foot. Staff E washed her hands and turned off the faucet with her right wrist, then grabbed paper towel to dry her hands. Interview completed on 2/25/26 at 11:23 AM revealed Staff E reported she utilized a clean barrier for Resident #37's supplies and wore gloves. She further explained Resident #37 has never been on EBP as he does not have any infection in his pressure ulcer wounds. Staff E reiterated EBP would only be required if Resident #37's pressure ulcers had infection present. Interview on 2/25 26 at 1:01 PM revealed the Infection Preventionist (IP) reported they have a monthly list that lists all residents that require EBP. Resident #37's name should be on the list for EBP. They communicate EBP through nursing and then they let the aides know because any long-term wounds can be easily infected. EBP should be in the resident's care plan and the staff should also go to the communication book for the resident EBP list. The IP explained EBP for wound care would require the use of gown and gloves. The gowns and gloves should be kept in the resident's room. The nurses are supposed to dispose of gloves, perform hand hygiene and then apply new gloves during a wound treatment. They nurses should be washing their hands between the glove changes. When washing hands, it would not be appropriate for a nurse to turn off the faucet with their wrist. A clean paper towel should be utilized. On 2/25/26 at 1:14 PM Staff E explained each Certified Nursing Aide (CNA) report book had a resident (continued on next page)

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	165338	A. Building B. Wing	03/04/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EBP list in the front of the manuals. Staff E pulled the EBP resident list from the manual. The EBP list failed to have Resident #37's name listed. Staff E acknowledged the EBP list was undated and voiced two of the residents on the list were recent catheters so she knew the list had been revised the past few weeks. The EBP list at the bottom documented, remember (you) must wear a gown and gloves when providing cares. During an interview on 2/25/26 at 2:05 PM the Director of Nursing (DON) reported Resident #37 was not on EBP. She had thought they needed to place residents on EBP for long-term wounds. She explained staff were to perform hand hygiene when changing gloves either by using hand sanitizer or washing their hands. She also observed Staff E should have changed her gloves after she cleansed Resident #37's heel before applying the clean dressing. The DON further voiced staff should turn off the faucet with a clean paper towel versus using their wrist. Clinical Record review on 2/25/26 at 2:30 PM of the Physician Orders revealed Resident #37 developed the right heel pressure wound on 10/4/25 and the Progress Notes revealed the development of a left heel pressure ulcer measuring 6 centimeters (CM) x 4 CM on 11/25/25. The Enhanced Barrier Precautions Policy revised 3/2024 provided by the facility documented a purpose to minimize the risk of transmission of novel or targeted Multi-Drug Resistant Organisms (MDRO) during high contact resident care activities for residents requiring EBP. The Policy under Procedure directed EBP will be used in conjunction with standard precautions for residents with wounds even if the resident is not known to have infection or colonization with a targeted MDRO. Note: wounds include chronic wounds including but not limited to, pressure ulcers. The Policy directed for resident whom EBP indicate a gown and gloves should be used during high contact resident care activities that provide opportunity for MDROs to be transferred to staff hands and clothing. High contact resident care activities include: wound care, any skin opening requiring a dressing. The Policy included a table under EBP that directed during wound care requiring a dressing, gloves and a gown should be worn prior to the high contact activity.

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	165338	A. Building B. Wing	03/04/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review, staff interviews and policy review the facility failed to provide informed consent regarding the risk and benefits for as needed psychotropic medications (medications that affect brain activity, influencing mood, thoughts, behavior, and perception to treat mental health conditions) for 1 of 3 residents reviewed for antipsychotic medications (Resident #7). The facility reported a census of 44 residents.Findings include: Review of Resident #7's Progress Notes written by his Doctor on 12/17/25 documented he continues to benefit from his medication ziprasidone (an antipsychotic given by a shot called an Intramuscular (IM) injection) and ABHR (ativan, benadryl, haldol, reglan) gel (a compounded gel medication that goes on the skin, containing Ativan/lorazepam (anti-anxiety medication), Benadryl/diphenhydramine (anti-histamine medication), Haldol/haloperidol (antipsychotic medication), and Reglan/metoclopramide (anti-dopaminergic) (a medication that blocks dopamine receptors, preventing dopamine from binding and reducing its activity)). Review of Resident #7 Medication Administration Record (MAR) documented current orders starting on 2/10/26:a. Ziprasidone 20 milligram's (mg) give IM every 12 hours ase needed for severe agitation related to his unspecified dementia, with psychotic disturbance for fourteen (14) days, then discontinue. b. ABHR gel (lorazepam 1mg, diphenhydramine 12.5 mg, haldol 2mg, reglan 20 mg per milliliter (ml), apply 1 ml of the gel to the skin every 4 hours as needed for aggression and anxiety related to his unspecified dementia, with psychotic disturbance and anxiety disorder for fourteen (14) days, then discontinue. Review of Resident #7 Progress Notes from 12/1/25 to 2/25/26 lacked documentation of family consent and education of adverse side effects regarding the risk and benefits of receiving as need antipsychotic medications of ziprasidone and ABHR gel. Review of Resident #7 current Care Plan on 2/25/26 instructed he is receiving antipsychotic, antidepressant and antianxiety medications to manage his impulsivity and keep him calm. In an interview on 3/3/26 at 3:15 PM with the Director of Nursing (DON) revealed psychotropic medication consents are completed in Assessment on the residents Electronic Health Record (EHR) and Resident #7 did not have ones completed for his ziprasidone and ABHR gel. Review of Resident #7 Assessments in his EHR (electronic health record) on 3/4/26 revealed he did not have an Assessment for completed for psychotropic medication consent for his ziprasidone and ABHR gel. In an interview on 3/4/26 at 10:07 AM with the Administrator informed Resident #7 family was very hard to get in contact with. Review of the facility's policy Usage for Psychotropic Medications Guidance last revised, 3/2025 instructed the facility will obtain informed consent from resident and/or their representative before initiating or increasing psychotropic medication use. Informed the resident, family, or representative of the benefits, risks, and alternatives, including black box warnings, before initiating or increasing medication.

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	165338	A. Building B. Wing	03/04/2026

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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 record review, staff interviews and policy review the facility failed to ensure non-pharmacological interventions were in place and anti-psychotics were used to treat relevant diagnoses and not a behavior (agitation) for 1 of 3 residents reviewed (Resident #38). The facility reported a census of 44 residents. Findings include: 1. The MDS assessment dated [DATE] for Resident #38 documented Brief Interview for Mental Status (BIMS) of 13 out of 15, indicating no cognitive impairment. The MDS documented he admitted to the facility on [DATE] and had diagnoses of non-Alzheimer's dementia with other behavioral disturbances, anxiety, and unspecified depression. Per this assessment, the resident had no hallucinations, no delusions, no physical or verbal behavioral symptoms directed towards others, no other behavioral symptoms not directed towards others, no rejection of care exhibited, and no wandering exhibited. Review of Resident #38's Medication Review Report signed by his Doctor on 1/28/26 indicated he had been taking seroquel (an antipsychotic medication used to treat schizophrenia, bipolar disorder, and major depressive disorder) 50 mg (milligram) daily for agitation and anxiety disorder since 10/24/2024. Review of Resident #38's Progress Notes from 1/1/2025 to 2/22/2026 revealed a Gradual Dose Reduction had not been completed for his seroquel medication, and his most recent gradual dose reduction on 8/27/25 at 9:50 AM revealed a request was denied by his Doctor for his anti-depressant, anti-anxiety medication and anti-psychotic medication with a rationale the benefits of the medications outweigh the risk and the medications enhance his ability to function at his highest functional level. Review of Resident #38's Care Plan on 3/3/26 revealed he was on an anti-psychotic medication and to attempt non-pharmacological intervention prior to use of psychotropic medications as of 10/21/24, but lacked non-pharmacological interventions. In an interview on 3/3/26 at 3:15 PM with the Director of Nursing (DON) explained Resident #38 did not have behaviors or psychotic episodes and his seroquel was being used to treat his anxiety. She also revealed he started on it after he was admitted to the facility, when he was a lot more agitated, but was not currently. In an interview with Resident #38's Doctor, the facility's Medical Director, on 3/4/26 at 8:40 AM revealed Resident #38 could do some gradual dose reduction on his medications, as he was not as aggressive anymore like he was in the past. Review of the facility's policy Usage for Psychotropic Medications Guidance, last revised 3/2025, instructed when prescribing new medications and/or increasing dosage the facility should, document non-pharmacological approaches used and their outcome. The policy also instructed to ensure and document psychotropic medications are necessary to treat specific, diagnosed, and documented conditions causing distress.

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	165338	A. Building B. Wing	03/04/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to code 1 of 2 residents catheter (Resident #38), 1 of 1 resident pressure ulcer (Resident #37), and 1 of 2 residents Preadmission Screening and Resident Review (PASRR) outcome (Resident #8) on the Minimum Data Set (MDS) assessment to reflect their current status at the time of the MDS assessment. The facility reported a census of 44 residents. Findings include:1. Resident #38's Medication Review Report signed by his doctor on 1/28/26 revealed an active order to continue use a of his catheter that started on 8/15/25. The MDS assessment dated [DATE] for Resident #38 documented a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating no cognitive impairment. The MDS documented a diagnosis of obstructive uropathy (a blockage in the urinary tract that hinders urine flow, causing it to back up into the kidneys and leading to potential damage), and that he did not have a catheter. 2. Resident #37's Wound Evaluation, dated 12/2/25 documented an assessment of a right heel unstageable facility acquired pressure ulcer that was identified at the facility on 10/4/25.The MDS assessment dated [DATE] for Resident #37 documented a BIMS of 15 out of 15, indicating no cognitive impairment. The MDS documented he did not have a pressure ulcer.3. Resident #8's current Preadmission Screening and Resident Review (PASRR) (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) dated 5/27/24 revealed he had a PASRR [NAME] II outcome (a determination that confirms an individual has a serious mental illness, intellectual disability, or related condition, and decides whether nursing facility placement is appropriate and if specialized services are needed).The MDS assessment dated [DATE] for Resident #8 documented a BIMS of 15 out of 15, indicating no cognitive impairment. The MDS documented he has diagnoses of anxiety and schizophrenia and did not have a PASRR Level II outcome.In an interview on 3/03/26 at 3:15 PM with the Director of Nursing (DON) revealed the MDS Coordinator had been doing MDS for approximately 2 years now she did them previously before. She informed Resident #38 has a catheter, Resident #8 was a PASRR level II, and Resident #37 had a pressure ulcer and should have been coded accurately to reflect each resident's status. In an interview on 3/4/26 at 12:23 PM with the MDS Coordinator explained Resident #38 did have a catheter, Resident #37 did have a pressure ulcer, and Resident #8 was a PASRR Level II. She revealed she had a system in place to complete MDS so they should not be coded inaccurately and had a Corporate staff member she could talk to if she would have question.

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	165338	A. Building B. Wing	03/04/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and resident and staff interviews the facility failed to provide care routine skin monitoring to cancerous lesions on the scalp and resident requested assessment/treatment for 1 of 3 residents reviewed for skin conditions (Resident #36). The facility also failed to maintain documentation that Neurological assessments (often called neuro checks) were performed after unwitnessed falls for 3 of 7 falls that indicated a need for neuro assessment monitoring (to detect serious, hidden brain injuries that might not be obvious right away, because bleeding or swelling in the brain can develop slowly over hours or even days, these tests are repeated to monitor for changes in a person's condition) for 1 of 1 resident reviewed for fall with major injury (Resident #7). The facility reported a census of 44 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #36 documented a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The MDS documented diagnoses of cancer, hypertension and dementia. Review of Resident #36's Medication Review Report signed by her Doctor/Medical Director on 1/22/25 instructed a twice a day treatment of hydrogen peroxide to her scalp, order date 5/22/24. An observation and interview on 2/22/26 at 3:03 PM with Resident #36 revealed she had been asking the nurse for 2 hours for them to take care of a skin site on her head. The scalp on the top of her head appeared to measure approximately 3 inches x 1 inch of loose dry skin with red beefy skin underneath.Observation of the nurses station revealed two nurses were sitting at the desk. They were made aware of Resident #36's complaint, and Staff B, Licensed Practical Nurse (LPN) came over and informed Resident #36 she would look at it when she was done giving report. An observation on 2/23/26 at 2:21 PM of Resident #36's scalp revealed the loose dry skin measuring 3 inches by 1 inch was no longer present on her scalp, and a large red scab present which measured approximately 3 inches by 1 inch. Review of Resident #36's Progress Notes from 2/21/26 to 2/24/26 lacked documentation and treatment regarding what happened to the loose skin on her scalp. Review of Resident #36's Care Plan on 2/25/26 revealed she had a history of an open areas on her scalp related to skin cancer on scalp and a scalp infection (created on 10/28/24 and last revised on 2/13/26). In an interview on 3/3/26 at 3:15 PM the Director of Nursing (DON) revealed Resident #36 had no active skin sheets, she had skin cancer on (her) head, previously they used a cream and put on the spots, and it changed recently due to it almost getting worse. Per the DON, stopped the treatment and the treatment changed to hydrogen peroxide. She revealed the facility planned on starting a skin sheet for her. In an interview on 3/4/26 at 8:40 AM, Resident #36's Doctor/Medical Director informed she had skin sites on her scalp since at least 2021 and right now they were consistent with squamous cell carcinoma. The Doctor/Medical Director further explained over the past few years he had ordered chemotherapy cream treatments. He explained it would probably never cure but are trying to minimize the impact it had on her life. He further explained the facility had completed labs in the past and she had completed courses of antibiotics and antifungal, but this had been an ongoing issue. He also explained she had no pain to the site, he looked at it usually every month when he visited, however it might not be documented. He further explained she (resident) is usually in the dining room and he could observe it. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) of 8 out of 15, indicating severe cognitive impairment. The MDS documented he was dependent on staff for walking and moving to desired locations in his wheelchair and was frequently incontinent of urine and bowel. The MDS also documented diagnoses of seizure disorder, anxiety, intellectual disabilities, and dementia with psychotic disturbances. The facility provided by e-mail correspondence a document titled Resident #7 Incident Reports, Notifications, and Neuros, the document included Resident #7's falls from 9/6/2025 to 2/25/2026. The document included paper Neurological Assessments that were completed after falls, Progress Notes, and Incident Reports. The following falls did not have (continued on next page)

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	165338	A. Building B. Wing	03/04/2026

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neurological (neuro) assessments and/or documentation of completed neurological assessments: a. On 9/6/25 at 1:31 AM he had an unwitnessed fall and a neuro assessment was started.b. On 9/8/25 at 10:17 AM he had a fall that was witnessed and he hit his head and a neuro assessment was started.c. On 11/24/25 at 2:20 AM he had an unwitnessed fall and a neuro assessment was not started. In an Email correspondence with Administrator on 3/2/26 at 11:14ˆAM revealed the following regarding Resident #7 falls: a. On 9/6/25 at 1:31 AM, neuros were completed per progress notes, but they were unable to locate the paper copy of neuro sheet.b. On 9/8/25 at 10:17 AM, neuros were completed per progress notes, but they were unable to locate the paper copy of neuro sheet.c. On 11/24/25 at 2:20 AM no neuro assessments completed. In an interview on 3/3/26 at 3:15 PM with the Director of Nursing (DON) explained usually once the neuro sheets were complete they got filed away, but she could not find them. Review of the facility's Fall Occurrence policy, revised 2/2024 instructed, in part, Neurological assessment will be initiated for unwitnessed falls and/or falls that are witnessed and the resident hits their head (neuros completed as directed on neuro flowsheet).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews and policy review the facility failed to provide restorative programs as directed for 2 of 2 residents reviewed for restorative and develop/implement a restorative treatment policy for the facility to follow (Resident #36 and #7). The facility reported a census of 44 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #36 documented a Brief Interview for Mental Status (BIMS) of 12 out of 15, indicating moderate cognitive impairment. The MDS also revealed she needed supervision/touching assistance to walk 10 feet but could not walk greater than 50 feet due to medical condition or safety concerns and needed partial to moderate assistance by staff when she used her manual wheelchair for distance greater than 50 feet. The resident had impairment on one side to her upper and lower extremity that interfered with daily function or placed her at risk for injury. The MDS documented diagnoses of cancer, hypertension and dementia. An observation of Resident #36 on 2/22/26 at 3:12 PM revealed she appeared to have limited Range of Motion (ROM) in both of her arms and legs. Review of Resident #36's January 2026 and February 2026 Documentation Survey Report V2 revealed she had 2 restorative programs in place: a. Restorative AROM (Active Range of Motion) Program: [Brand Name Redacted of Recumbent Cross Trainer Machine], level 3 for 15 minutes OR active range of motion exercises to arms and legs, all motions. (arm exercises using green theraband, leg exercises using a one-pound weight, rest breaks as needed. Repetitions/Durations: 20 repetitions. OR active range of motion to arms and legs (arm exercises using the arm bike, light resistance for 5-8 minutes, leg exercises using a one-pound weight, 20 repetitions x 2, standing exercises, and choice of task: sort cards, weighted clothes pins, large pegs.) 15 minutes per day as tolerated 3 times a week and as needed.b. Restorative Walking Program (includes minutes only): Ambulate with front wheeled walker, one staff assist, and gait belt distance as tolerated everyday. In January 2026 the report revealed she did not complete/facility did not offer her Restorative AROM Program 6 times and Restorative Walking Program 1 time.In February 2026 the report revealed she did not complete/facility did not offer her Restorative AROM Program at all for the whole month (12 times) and Restorative Walking Program 5 times.Review of Resident #36's Progress Notes lacked nursing review of her Restorative Program and progression or decline from 3/1/25 to 3/4/26. Review of Resident #36's Care Plan on 2/25/26 documented a goal that she will improve/maintain her current ROM to arms (goal date initiated 2/20/25), with interventions to encourage her to participate in restorative programs, follow therapy recommendations as applicable, and provide resident with required assistive devices such as wheelchair and walker.2. The MDS dated [DATE] for Resident #7 documented a BIMS score of 8 out of 15, indicating severe cognitive impairment. The MDS documented he was dependent on staff for walking and moving to desired locations in his wheelchair and was frequently incontinent of urine and bowel. The MDS also documented diagnoses of seizure disorder, anxiety, intellectual disabilities, and dementia with psychotic disturbances.Review of Resident #7's January 2026 and February 2026 Documentation Survey Report V2 revealed he had 1 restorative program in place: a. Restorative AROM (Active Range of Motion) Program: [Brand Name Redacted of Recumbent Cross Trainer Machine], level 4 for 15 minutes per day as tolerated. In January 2026 the report revealed he did not complete/facility did not offer his Restorative AROM Program 10 times and he refused it 3 times. In February 2026 the report revealed he did not complete/facility did not offer his Restorative AROM Program 10 times and he refused 1 time. Review of Resident #7's Progress Notes lacked nursing review of his Restorative Program and progression or decline from 2/20/26 to 2/25/26. Review of Resident #7's Care Plan on 2/25/26 instructed he was on a Restorative Nursing Program to help achieve and maintain optimal physical, mental, and psychosocial health (date initiated 2/20/25), with intervention to encourage him to participate in restorative programs and follow therapy (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation as applicable (intervention dates 2/20/25). In an interview on 2/24/26 at 2:33 PM with the Administrator revealed the restorative programs for all residents are in their Electronic Health Record (EHR) and are documented under the task section. She informed the facility did not have a formal restorative program, it was strictly to maintain the resident's current functional ability. In an e-mail correspondence with the Administrator on 3/2/36 at 1:05ˆPM revealed the facility did not have a policy related to restorative programs, because they did not have a formal Restorative Program in which they captured restorative minutes on the MDS. The person who did the restorative was a Certified Nurse Assistant (CNA). In an interview on 3/3/26 at 3:15 PM, the Director of Nursing (DON) explained the MDS Coordinator put the Restorative Programs into the EHR and then she made a copy so people could see them and she lets Staff I, CNA know. She explained she did not complete monthly or quarterly progress notes and neither did the MDS Coordinator. In an interview on 3/4/26 at 12:23 PM with the MDS Coordinator explained she put Restorative programs in the EHR for the staff to do and if the program changes or was discontinue she updated the Care Plan but did not complete routine progress notes or evaluation of the restorative programs. In an interview on 3/4/26 at 12:49 PM with Staff I, Certified Nurse Assistant (CNA) explained Resident #7 would ride the bike depending on his mood and she felt she had enough time to complete restorative programs. She informed if she saw a decline in a resident she would tell the nurse on duty or the DON, but she really hasn't had to do that for anyone recently. She also informed in the past a nurse used to watch her complete so many residents programs a month, but no one had done that for awhile.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to complete a root cause analysis after each fall to ensure an intervention to prevent future falls was put in place, and failed to ensure the intervention was related to the reason the fall occurred for 1 of 1 resident reviewed for fall with major injury (Resident #7). The facility also failed to update the Care Plan timely related to falls for Resident #7. The facility reported a census of 44 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) of 8 out of 15, indicating severe cognitive impairment. The MDS documented he was dependent on staff for walking and moving to desired locations in his wheelchair and was frequently incontinent of urine and bowel. The MDS also documented diagnoses of seizure disorder, anxiety, intellectual disabilities, and dementia with psychotic disturbances. Review of Resident #7's current Care Plan on 2/25/26 revealed the resident was at risk for unavoidable falls related to history of falls, Epilepsy, BPH (Benign Prostatic Hyperplasia), dementia, intellectual disability, anxiety disorder, impulsivity, and poor decision making. The following fall interventions, with date created in the computer, were on the current Care Plan: a. 10/28/24 call light within reach and assist with ambulation and transfers as needed.b. 9/23/25 hi/low bed and keep bed in lowest position when he is in it. c. 9/22/25 pressure alarm in bed and pull tab alarm when in wheelchair/recliner.d. 10/2/25 use body pillow when in bed for positioning and landing strip next to bed.e. 10/3/25 offer and assist with toileting frequently.f. 10/6/25 when anxious attempt to assist to the bathroom.g 11/18/25 ensure is place in a comfortable position and frequent reposition changes in place.h. 11/19/25 use distraction techniques with him during times of anxiety.i. 11/20/25 distract him during shift changes so he does not see staff leaving. j. 11/25/25 he may put himself on the floor and stay there if he is safe until he is ready to get up, staff are to ensure safety while on the floor. k. 12/11/25 toilet every 2 hours while awake.l.12/16/25 gait belt available on his wheelchair.m. 1/6/25 move to a quiet are when he becomes agitated. n. 1/9/26 monitor in dining room when play cares and assist so he is not stand up or reaching for objects.o. 1/27/26 non-skid footwear and assist to quieter environment when he is in a noisy environment and has signs of agitation, anti-tippers to wheelchair, bed is in a low position when resident is in bedp. 2/10/26 when attempting to get up assist with repositioningq. 2/23/26 assist to bathroom prior to meals.r. 2/10/26 assist to bathroom after supper meal. The facility provided by e-mail correspondence document titled Resident #7 Incident Reports, Notifications, and Neuros. The document included Resident #7's falls from 9/6/2025 to 2/25/2026, the document included paper Neurological Assessments that were completed after falls, Progress Notes, and Incident Reports. Review revealed, in part, the following: a. On 9/14/25 at 8:45 PM he had an unwitnessed fall in another residents room.b. On 9/19/25 at 1:37 PM he had a witnessed self transfer fall after using the hand pedal bike in the dining room.c. On 11/24/25 at 2:20 AM he had an unwitnessed fall in the dining room.d. On 11/27/25 at 3:30 AM he had a witnessed fall in the dining room when staff were attempting to assist.e. On 12/26/25 at 12:20 PM he had a witnessed fall at the nurses station.f. On 12/29/25 at 4:53 PM he had a witnessed fall in the dining room. Review revealed the following falls did not have root cause analysis and relevant interventions put in place to address the fall; 9/14/25 at 8:45 PM, 9/19/25 at 1:37 PM, 11/24/25 at 2:20 AM, 11/27/25 at 3:30 AM, 12/26/25 at 12:20 PM, and 12/29/25 at 4:53 PM. In an Email correspondence with Administrator on 3/2/26 at 11:14ˆAM revealed the following regarding Resident #7's falls: a. On 9/14/25 at 8:45 PM his fall intervention was a pad alarm at all times.b. On 9/19/25 at 1:37 PM his fall intervention was a mattress on the floor and a high-low bed.c. On 11/24/25 at 2:20 AM his fall intervention was that he may put himself on the floor and stay there until he is ready to get up and Staff are to check on him to ensure safety while he is on the floor. d. On 11/27/25 at 3:30 AM his fall intervention was to offer and assist with toileting (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequently.e. On 12/26/25 at 12:20 PM his fall intervention was to take him to the bathroom and offer to lie down.f. On 12/29/25 at 4:53 PM his fall intervention was to place a pad alarm under his cushion in the wheelchair. The Incident Reports, Notifications, and Neuros document also informed the following falls resulted in him going to the emergency room (ER) and resulted with treatment for fractures: a. On 11/4/25 at 4:00 PM he had an unwitnessed fall in the dining room, alarm was going off, staff ran to answer the alarm but he was on the floor. The resident was sent to the ER for evaluation for left wrist pain and swelling. Review of Resident #7's Progress note on 11/4/2025 at 4:27 PM documented he returned from the ER (Emergency Room) and had a traumatic closed fracture of ulnar styloid with minimal displacement, left initial encounter (crack in the small bony bump on the outside of left wrist (near the pinky side) caused by a sudden injury) and Traumatic closed torus fracture of metaphysis of left distal radius with minimal displacement, initial encounter (wrist fracture where the bone has slightly buckled or compressed after a fall, rather than breaking all the way through). A wrist splint was placed on his left hand and was to remain on for 6 weeks. b. On 1/8/26 at 2:58 PM he had a witnessed fall in the dining room and was sent to the ER for evaluation due to pain in his right elbow, right hip and left shoulder. Review of Resident #7's Progress Note on 1/8/2026 at 9:42 PM documented he returned from the ER at at 7:30 PM and has a closed fracture of his distal ulna (a break in the forearm bone) located on the pinky-finger side, right near the wrist) and was to wear a splint to the affected arm for now and family may be interested in surgical repair. He also needed to wear an arm sling to his right arm for comfort and keep right his arm elevated when possible. In an interview on 3/4/26 at 8:40 AM with Resident #7's Doctor/Medical Director revealed Resident #7 entered the facility with a seizure disorder and his intellect was also vastly declining. Nurses would ask for the past year as he to declined if it was related to pain or what was going on. His fractures did not slow him down. His vascular dementia probably started about 2 years ago and his rapid decline started in February 2026, with a failure to thrive and became anorexic and would not drink anything. The Doctor/Medical Director revealed attempted to get him into to a geriatric psychiatric nursing facility but nothing was available. He could be very violent, and then became more frail as he declined. His falls were 100% percent unavoidable, and could not even make him a one to one with staff because if one person was in his face all the time that would make him even more aggressive. Per the Doctor/Medical Director, could have put 6 alarms on him but no matter what he was still going to take the first 2 steps and fall, and just couldn't catch him. The Doctor/Medical Director explained thought the facility did the best they could. In an interview on 3/3/26 at 3:15 PM with the Director of Nursing (DON) explained Resident #7 really started to have changes in September 2025, and were unable to do a lot because his behaviors were so extreme. Per the DON, thought he might of started to have some terminal restlessness in January 2026. He was a very busy guy and resistive to cares. Per the DON, reviewed falls daily at Interdisciplinary Team (IDT) meetings, and the Administrator took notes, but she did not have a formal tracking sheet regarding each one of Resident #7's falls and finding the root cause analysis. Review of the facility's Fall Occurrence policy, revised 2/2024 instructed, in part, the following: 2. Based on assessment, interventions are implemented and placed on the resident Care Plan .6. Additional intervention(s) will be implemented post fall. The IDT team may the the intervention(s) if the IDT investigation identifies a more appropriate intervention for the individual fall .7. The Resident's Care Plan will be updated with any new or revised interventions(s).