STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165570	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Heights Care Center	1514 High Avenue West Oskaloosa, IA 52577

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Clinical record review and staff interview, the facility failed to follow medication administration protocol resulting in the wrong medication being administered. (Resident#1). The facility reported census was 70. Findings include: According to a Minimum Data Set (MDS) with a reference date of November 7, 2025, Resident #1 had a Brief Mental Status (BIMS) score of 0 of 15 indicating a severely impaired cognitive status. Resident #1 required moderate to maximal assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included Non-Alzheimer's dementia, cancer, renal insufficiency, arthritis, diabetes mellitus, gastroesophageal reflux disease and malnutrition.According to Resident #1's Care Plan, Resident #1 was diagnosed with diabetes mellitus with risk for hypoglycemia (low blood sugar) and interventions which included fasting serum blood sugars as ordered, monitor for hypoglycemia and provide diabetic medications as ordered.Review of Resident #1's physician orders found an order for blood glucose checks before meals and at bedtime starting 11/4/25.Medication Administration Records (MARS) for November 2025 revealed Resident #1 was admitted on [DATE] with no initial order for insulin. On 11/15/25, Resident #1 was started on Tresiba 26 units at bedtime following blood sugars exceeding 300 days earlier. On 11/18/25 the Tresiba order was changed to 26 units in the morning daily. On 11/27/25 Resident #1's Tresiba 26 units every morning was discontinued following an event in which Resident #1's blood sugars fell below 40.In an interview on 12/8/25 at 7:12 a.m. Staff A, Registered Nurse, stated at around 2:05 a.m. on 11/26/25, staff had reported Resident #1 was experiencing increased confusion and earlier that day had had low blood sugars. Staff A stated he checked her blood sugar and it was 38 mg/dL. (milligrams per deciliter) Staff A stated there was no order for Glucagon and he called the nurse practitioner (ARNP) and received an order. Staff A stated he removed a syringe of medication from the compartment in the ekit labeled Glucagon and administered the contents in the syringe. Staff A stated 5 minutes later he checked the blood sugar again and this time it was 36 mg/dL. Staff A stated he called the ARNP again and received an order to give another dose of Glucagon. Staff A returned to the ekit and removed another syringe from the compartment labeled Glucagon and administered the contents. Five minutes later he checked the blood sugar and it was lower yet, prompting him to call for an ambulance. Within a few minutes, the emergency medical technicians (EMT) arrived and took over care for Resident #1, including administering intravenous 50% dextrose. Staff A returned to his medication cart and began documenting the event. Upon looking at the syringes he had administered, he noted the medication given was not Glucagon, but instead Enoxaparin, an anticoagulant used to prevent or treat dangerous blood clots. Staff A stated the pharmacy had errantly placed the Enoxaparin syringes in the compartment labeled Glucagon. Staff A stated he immediately informed the EMTs and contacted the ARNP of his error. Staff A stated Resident blood sugars returned to 200 mg/dL, but her mental status remained altered (not related to the Enoxaparin) and she was sent to ER for further observation.In an interview on 12/2/25 at 2:14 p.m. the Director of Nursing (DON) was questioned regarding a medication error in which Staff A removed what he believed was Glucagon from the ekit (emergency supply tackle box) and administered two doses of Enoxaparin 100 milligram/1 milliliter to Resident #1. The DON stated Resident #1 was having a hypoglycemic episode with blood sugars critically low in the thirties. The DON stated Resident #1 was not responding and Staff A notified emergency medical services (EMS). Once EMS took over the care of Resident #1, Staff A went to the trash can and removed the packaging, discovering at that time he had given Enoxaparin (anticoagulant) instead of Glucagon (glucose booster). Further investigation revealed the pharmacy had incorrectly placed Enoxaparin syringes in the Glucagon compartment and Glucagon syringes in the Enoxaparin compartment.