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	06/26/2025

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 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. 3. On 6/25/25 at 8:05 AM, observation of Resident #14 revealed the resident was sitting in the dining room with Staff A, LPN (Licensed Practical Nurse), next to her. Staff A fed the resident a bite of oatmeal. Resident #14 said, That's too hot. Staff A responded that it wasn't too hot and tried to give the resident another bite. Resident #14 stated, If you burned your mouth you would think it was too hot too. Resident #14 refused to eat any more of the oatmeal. Based on observation, clinical record review, and staff interview, the facility failed to treat 2 of 5 residents reviewed for dignity with respect by failing to assist a resident to the bathroom when the need was voiced (Residents #14 and #44) and by failing to acknowledge a resident's food temperature preferences (Resident #14). The facility reported a census of 62 residents. Findings: 1. The Annual Minimum Data Set(MDS) assessment tool, dated 5/28/25, listed diagnoses for Resident #44 which included anxiety disorder, severe intellectual disability, and depression. The MDS stated the resident required partial to moderate assistance for toileting hygiene and toileting transfers and listed the resident's Brief Interview for Mental Status (BIMS) score as 0 out of 15, indicating severely impaired cognition. 6/15/22 Care Plan entries stated the resident had a behavior problem and was tearful, had verbal outbursts, and laid on the floor crying due to mild intellectual disabilities. The Care Plan entry directed staff to anticipate the resident's needs. A Care Plan entry, revised 3/16/23, stated the resident called for assistance with incontinence episodes when needed. On 6/26/25 at 10:53 a.m., Staff A Licensed Practical Nurse(LPN) stated Staff D Certified Nursing Assistant(CNA) did not get along with Resident #44. She stated she observed the resident tell Staff D that she had to go to the bathroom and Staff D stated to her that it was not time yet and did not assist her. Staff A stated she talked to the Assistant Director of Nursing(ADON) about it. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 11:21 a.m., Staff D CNA stated Resident #44 had a lot of behaviors and asked to go to the bathroom multiple times. She stated they assisted her to the toilet multiple times when she did not end up urinating or defecating. Staff D questioned what they should do when they had other residents to assist to the bathroom who did have to go. She stated they had Resident #44 on a two hour schedule and they tried to keep it consistent. She stated there were times when the resident wanted to go to the bathroom and she(Staff D) told her it was not time yet. 2. The Quarterly MDS assessment tool, dated 5/14/25, listed diagnoses for Resident #14 which included Alzheimer's disease, anxiety disorder, and weakness. The MDS stated the resident required substantial to maximal assistance for toilet transfers and was dependent on staff for toileting hygiene. The MDS listed her cognition as severely impaired. A 9/13/23 Care Plan entry stated the resident required the assistance of two staff for toileting needs. On 6/24/25 at 11:36 a.m., Resident #14 sat at a dining room table and drank approximately 240 milliliters(ml) of chocolate milk. Staff then provided her another cup of milk and she drank a portion of this as well. At 11:55 a.m., Staff I CNA fed the resident and the resident stated she had to go to the bathroom. Staff J CNA stated to Staff I that it was hard to tell with Resident #14 and told Staff I that if she said she had to go to the bathroom again, then to take her. Staff I did not take the resident to the bathroom and continued to feed her. The resident remained in the dining room until 12:08 p.m. On 6/26/25 at 10:53 a.m., Staff A LPN stated if Resident #14 stated she had to go to the bathroom, staff should take her. On 6/26/25 at 11:21 a.m. Staff D CNA stated if Resident #14 asked to go to the bathroom, she would take her. She stated the resident did urinate in the toilet. On 6/26/25 at 12:19 p.m., The Assistant Director of Nursing(ADON) stated if Resident #14 stated she had to go to the bathroom, staff should assist her. She stated this also applied to Resident #44. She stated she did not hear of anyone not taking Resident #44 to the bathroom when she had to go. On 6/26/25 at 2:23 p.m., via email, the ADON stated the facility did not have a policy related to dignity.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure residents had ready access to their personal funds for 1 of 1 residents reviewed for personal funds(Resident #33). The facility reported a census of 62 residents. Findings include: The Annual Minimum Data Set (MDS) assessment tool, dated 4/23/25, listed diagnoses for Resident #33 which included diabetes, non-Alzheimer's dementia, and anxiety disorder. The MDS listed the resident's Brief interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. On 6/24/25 at 10:27 a.m., Resident #33 stated she requested money on Monday(6/23/25) from the Business Office Manager (BOM) but she told her she would not go to the bank until Thursday(6/26/25). On 6/25/25 at 1:10 p.m., the BOM stated she handled resident funds in the facility. She stated she normally went to the bank on Thursday. She stated on Monday, Resident #33 requested money and she told her she couldn't get to the bank until Thursday. On 6/26/25 at 12:19 p.m., the Assistant Director of Nursing (ADON) stated residents should have access to their money and it was her understanding they did. The undated facility policy admission Agreement-Personal Property, stated the facility would hold and safeguard a small amount of money in accordance with State Resident Fund/Trust Account laws and/or facility policies and would provide (money) upon request.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Code Status Form, observation, record review and interview the facility failed to ensure consistent documentation of code status for 1 of 24 resident reviewed for advanced directives (Resident #15). The facility reported a census of 72 residents. Findings include: The Code Status form signed by Resident #15 on [DATE] directed CPR referring to cardiopulmonary resuscitation. The Care Plan initiated [DATE] for Resident #15 lacked code status and did not indicate hospice services. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 on hospice services. Medical diagnoses included heart disease, renal disease, diabetes and dementia. The Brief Interview for Mental Status (BIMS) exam scored 3 out of 15 indicating severe cognitive deficits. The Pocket Care Plan (condensed Care Plan directing resident cares) undated directed CPR. Observation of the Binder (chart) for Resident #15 directed Do Not Resuscitative (DNR) was wrote on the spine of the binder. The Electronic Census record revealed Resident #15 started hospice services on [DATE]. An interview with Assistant Director of Nursing (ADON) on [DATE] at 9:54 AM relayed was not sure if CPR status had changed with start of hospice services and acknowledged the concern with the code discrepancies. The ADON reported she would look into this immediately to ensure residents wishes are followed. A policy on Advance Directives was not available.

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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 clinical record review, observation and staff interviews, the facility failed to ensure staff completed the assessment of residents to accurately reflect their status for 2 of 19 sampled residents (Resident #18 and #12). The facility reported a census of 62 residents. Findings included: 1. The Quarterly Minimum Data Set (MDS) assessments for Resident #18, dated 3/5/25 and 6/4/25, identified a diagnosis of Alzheimer's and an admission date of 12/7/22. The assessment included documentation that the resident was dependent on staff for toileting, bathing, lower body dressing, transfers and substantial or maximum assistance for personal hygiene and rolling in bed from one side to another. The resident used a wheelchair for mobility and did not walk or stand. Her Brief Interview for Mental Status (BIMS) was documented as severely impaired with no assessed score. The same MDS assessment documented the resident did not have a impairment to upper or lower extremities. On 6/25/25 at 8:18 AM, during an interview, Staff F, Registered Nurse (RN), reported she had worked at the facility for 11 years and knew Resident #18 well. Staff F reported Resident #18 did not walk and had impairments to her bilateral lower extremities. Staff F reported the resident was a Hoyer (type of mechanical lift transfer used for dependent residents who were unable to safely stand). Staff F thought the resident had been a Hoyer transfer for the last year. On 6/25/25 at 8:37 AM, during an observation, Staff K, Certified Nurses Aide (CNA), and Staff L, CNA, transferred the resident with a Hoyer lift. The resident was dependent on staff during the transfer and did not move her lower extremities. In an interview during the same observation, Staff K, CNA, reported that staff had been utilizing the Hoyer lift for transfers with Resident #18 for a couple years. Staff K, CNA explained the resident utilized a standing mechanical lift prior to the Hoyer, but became a Hoyer lift transfer when the resident was no longer able to stand. On 6/25/25 at 2:45 PM, during an interview, Staff A, Licensed Practical Nurse (LPN), reported she was the restorative nurse for all of the residents at the facility. Staff A reported Resident #18 participated in both individual and group range of motion (ROM) activities. Staff A reported the resident did not have real good range of motion in the bilateral lower extremities. Staff A further explained she performed passive (resident did not independently move) ROM on Resident #18's bilateral lower extremities. Staff A explained that she was unable to do full range of motion on the lower extremities due to the resident being stiff. Staff A clarified that the resident had limited ROM and limited impairment to the bilateral lower extremities. Staff A reported the resident was admitted to the facility with a limited impairment to the lower extremities and was limited even when the resident used the EZ stand (type of lift where the resident stands with mechanical support. Facility staff inaccurately coded the MDS to indicate Resident #18 did not have an impairment bilaterally to the lower extremities. On 6/26/25 at 1:29 PM, in an email response, the Assistant Director of Nursing reported the facility did not have an MDS assessment policy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Quarterly MDS dated [DATE] for Resident #12 documented diagnosis of heart disease, diabetes and lung disease. The MDS coded resident used a invasive mechanical ventilator or respirator within the last 14 day look back period. An observation on 6/23/25 2:01 PM Resident #12 did not use a ventilator, room was not set up for a ventilator/respirator. During an interview on 6/25/25 at 2:52 PM the Advanced Registered Nurse Practitioner (ARNP) reported Resident #12 had not been on a ventilator. During an interview with the Assistant Director of Nurses (ADON) on 6/25/25 at 3:01 PM confirmed resident #12 did not require ventilator/respirator while at the facility and the MDS was coded in error.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure the Care Plan identified Hospice services, correct transfer status, activities, and behavioral interventions for Post-Traumatic Stress Disorder (PTSD), and lacked documentation of care conferences conducted for 7 of 19 residents reviewed for Care Plans (Residents #15, #33, #34, #37, #44, #56 #61). The facility reported a census of 62 residents. Findings include: 1. The Quarterly Minimum Data Set(MDS) assessment tool, dated 4/23/25, listed diagnoses for Resident #33 which included diabetes, non-Alzheimer's dementia, and anxiety disorder. The MDS listed the resident's Brief interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. On 6/24/25 at 10:27 a.m., Resident #33 stated the facility did not invite her to care conferences. A Care Conference Summary, dated 4/23/25, stated the resident had a care conference in her room with a staff nurse and the Assistant Director of Nursing(ADON). The facility lacked documentation of additional care conferences held during the survey year(8/8/24-6/23/25). On 6/25/25 at 9:17 a.m., the Assistant Director of Nursing(ADON) stated there was a change in personnel and she could not locate any care conferences prior to April 2025. 2. The Annual MDS assessment tool, dated 5/28/25, listed diagnoses for Resident #44 which included anxiety disorder, severe intellectual disability, and depression. The MDS stated the resident required partial to moderate assistance for transfers and listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 15, indicating severely impaired cognition. A 6/15/22 Care Plan entry stated the resident was independent with transfers. The Care Plan failed to reflect the MDS with the direction that the resident required assistance with transfers. On 6/25/25 at 7:55 a.m. Staff L and M Certified Nursing Assistants(CNAs) transferred the resident from her wheelchair to the toilet using a gait belt. The resident required substantial assistance(lifting and stabilizing) from the CNAs to complete the transfer. On 6/26/25 at 8:17 a.m., Staff G CNA stated Resident #44 required the assistance of two staff to get to the toilet. On 6/26/25 at 12:19 p.m., The ADON stated the Care Plan should reflect correct transfer statuses. 3. The Quarterly MDS assessment dated [DATE] for Resident #15 documented diagnosis, non-Alzheimer's Dementia. The MDS coded Resident #15 received hospice care. The Clinical Census, Electronic Health Record (EHR) revealed Resident #15 hospice care began 10/25/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan for Resident #15 was not updated to reflect that the resident received hospice services. 4. The MDS assessment for Resident #37 dated 5/21/25 revealed diagnosis of Alzheimer's diseases, early onset , no completed BIMS assessment, was coded rarely or never understood. The Clinical Census, Electronic Health Record (EHR) revealed Resident #37 admitted [DATE]. The Care Plan for Resident #37 documented behavior symptoms related to Alzheimer's revision dated 12/10/21 directed encourage group activity, to engage in simple structured activities, did not provide updates or information on resident interest or preference, lacked details, activity options or guidance to support physical mental or psychosocial well-being. 5. The Quarterly MDS assessment for Resident #56 dated 5/7/25 revealed unspecified mild dementia. The BIMS assessment scored 9 out of 15 indicated moderate cognitive decline. The Clinical Census, Electronic Health Record (EHR) revealed Resident #56 admitted [DATE]. The Care Plan for Resident #56 documented inaccurate BIMS score of 4 and did not provide updates or information on resident interest or preference, lacked details, activity options or guidance to support physical mental or psychosocial well-being. 6. The MDS dated [DATE] for Resident #61 revealed diagnosis included Non-Alzheimer's Dementia and BIMS assessment score of 3 indicated severe cognitive impairment. The Care Plan initiated 5/19/25 was not updated to reflect dressing, eating, hygiene, toileting or transfer intervention, areas left blank. The Care Plan did not provide updates or information on resident interest or preference, lacked details, activity options or guidance to support physical mental or psychosocial well-being. On 6/26/25 at 12:15 PM The ADON relayed awareness of need to expand on Care Plans updates, felt the newly hired staff would be helpful. Facility Policy titled Activities, not dated revealed activity interests will be identified in the residents plan of care and reviewed quarterly . The undated facility policy Comprehensive Resident Plan of Care stated resident needs were addressed within the comprehensive plan of care and stated the development of the plan of care included the resident. The policy stated the Care Plan would reflect changes and stated care conferences would occur quarterly.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, representative, staff interviews, record review, and facility policy review the facility failed to provide the residents in the Chronic, Confusion, and Dementia Illness (CCDI) unit a activity program built to meet the interests of and support the physical, mental and psychosocial well-being of each resident. Findings include: 1. A Quarterly Minimum Data Set, dated [DATE] for Resident #15 documented diagnosis, non-Alzheimer's dementia and coded wore a wander/elopement alarm. The Brief Interview for Mental Status (BIMS) assessment coded 00 to reflect resident, was not able to take assessment. In an interview on 6/23/25 at 4:34 PM with representative of resident #15 relayed there is nothing at all related to activities and is concerning, had not seen or heard of any activities, never seen anything posted, relayed books are provided but, did not think reading was an option anymore due to dementia progression and Resident #15 no longer wearing her glasses. 2. The MDS assessment dated [DATE] for Resident #61 revealed BIMS assessment of 3 indicated severe cognitive impairment. The diagnosis included Non-Alzheimer's Dementia. In an Interview on 6/23/25 with Resident #61 spouse, relayed would like to see activities in the unit, relayed there are none here, referred to the locked memory care unit. When queried about an activity calendar, resident representative reported not aware of any activity calendar. Representative revealed would have to take spouse outside of the memory care unit to take part in activities and am not always here to do that. 3. The Quarterly MDS assessment dated [DATE] for Resident #56 revealed BIMS score of 9 indicated moderated cognitive impairment. The diagnosis included Non-Alzheimer's unspecified dementia, mild without behavioral, mood or anxiety disorders In an interview on 6/23/25 at 11:57 AM Resident #56 relayed there is nothing to do, not aware of any activities, does own puzzles in her room, was not aware of activities outside of the unit as an option. After discussion, Resident #56 revealed was not aware of church services in the common area outside of the unit on Sunday and is interested, had never seen an activity calendar. 4. The Quarterly MDS assessment for Resident #37 dated 5/21/25 revealed diagnosis of Alzheimer's diseases, early onset and was not unable to conduct the BIMS assessment, was coded rarely or never understood. Observation on 6/25/25 3:00 PM to 4:08 PM Resident #37 walked back and forth in the unit without purpose. During a confidential interview on 6/25/25 at 4:08 PM it was relayed Resident #37 usual behavior is walking back and forth, relayed would like to see staff directed activities for all the residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The Quarterly MDS assessment dated [DATE] documented Resident #45 was unable to conduct a BIMS assessment. The Clinical diagnosis documented in Resident#45's Electronic Health Record (EHR) included vascular dementia. On 6/23/25 at 4:34 PM the family visiting Resident #45 reported the residents usual behavior of walking back and forth with her head down, was usual daily behavior. The family reported wishing there were activities for the residents in the unit. In an interview on 6/25/25 at 4:40 PM Staff H, Activity Staff relayed last year they did have an activity person that concentrated on the memory care unit, but thought that staff left in December and did not get a replacement. Staff F, Registered Nurse acknowledged there is no activity calendar and the CNA in the unit is expected to fit in activities when they have time. Activity Staff H acknowledged CNA staff may not have time. In an interview on 6/25/25 on 4:41 PM The Business Office Manager (BOM)/Provisional Administrator acknowledged there is no activity calendar for the memory care unit, and thought the residents may join in the common area for activities if desired. A facility email on 6/26/25 at 10:42 AM an email relayed the Certified Activity Coordinator is also the Provisional Administrator (also has the role of BOM) . The email relayed Activity Staff H operates under the Administrator/BOM certification. Facility Policy titled Activities, not dated revealed the objective is to provide a stimulating and fulfilling activity program designed to meet resident individual needs, to achieve satisfaction and contentment. The process included to gather information about interest, share information with staff to ensure meaningful activities aligned with interests and needs in individual and group settings. Activities to be planned related to gathered information and encouraged. Staff to document resident participation. The Activity Director will update the calendar of events. Activity assessments will be completed with the comprehensive assessment, quarterly and as needed in accordance with state and federal regulations. Activity interests will be identified in the resident's plan of care and reviewed quarterly.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, clinical record review, policy review, and staff interview, the facility failed to assist 1 of 2 residents reviewed for toileting assistance to the bathroom when the need was voiced(Resident #14). The facility reported a census of 62 residents. Findings include: The Quarterly Minimum Data Set(MDS) assessment tool, dated 5/14/25, listed diagnoses for Resident #14 which included Alzheimer's disease, anxiety disorder, and weakness. The MDS stated the resident required substantial to maximal assistance for toilet transfers and was dependent on staff for toileting hygiene. The MDS listed her cognition as severely impaired. A 9/13/23 Care Plan entry stated the resident required the assistance of two staff for toileting needs. On 6/24/25 at 11:36 a.m., Resident #14 sat at a dining room table and drank approximately 240 milliliters(ml) of chocolate milk. Staff then provided her another cup of milk, and she drank a portion of this as well. At 11:55 a.m., Staff I Certified Nursing Assistant(CNA) fed the resident and the resident stated she had to go to the bathroom. Staff J CNA stated to Staff I that it was hard to tell with Resident #14 and told Staff I that if she said she had to go to the bathroom again, then to take her. Staff I did not take the resident to the bathroom and continued to feed her. The resident remained in the dining room until 12:08 p.m. On 6/26/25 at 10:53 a.m., Staff A Licensed Practical Nurse(LPN) stated if Resident #14 stated she had to go to the bathroom, staff should take her. On 6/26/25 at 11:21 a.m. Staff D CNA stated if Resident #14 asked to go to the bathroom, she would take her. She stated the resident did urinate in the toilet. On 6/26/25 at 12:19 p.m., The Assistant Director of Nursing(ADON) stated if Resident #14 stated she had to go to the bathroom, staff should assist her. The undated Toileting and Check and Change Policy directed staff to toilet residents before and after meals and as needed throughout the day.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure 1 of 1 resident reviewed for pain received treatment and care related to pain management(Resident #14). The facility reported a census of 62 residents. Findings include: The Quarterly Minimum Data Set(MDS) assessment tool, dated 5/14/25, listed diagnoses for Resident #14 which included Alzheimer's disease, anxiety disorder, and weakness. The MDS stated the resident was on scheduled pain medication and had no indicators of pain such as vocal complains or non-verbal sounds. The MDS listed her cognition as severely impaired. On 6/24/25 at 8:11 a.m., Resident #14 stated I hurt multiple times throughout out breakfast. Multiple staff were present in the dining room including Staff A Licensed Practical Nurse(LPN). On 6/24/25 at 11:55 a.m., Staff I Certified Nursing Assistant(CNA) fed the resident and Staff J CNA sat with another resident. The resident stated she hurt. Care Plan entries, dated 2/10/20, stated the resident reported frequent pain and discomfort to her right hip and utilized scheduled pain medications/ The entries directed staff to attempt three non-pharmacological pain interventions prior to the initiation of as needed(prn) pain medications, administer medications as ordered, and evaluate the effectiveness of pain interventions. The June 2025 Medication Sheet listed an 8/25/23 order for Acetaminophen(a non-narcotic pain medication) 2 tablets every 6 hours as needed. The record lacked documentation staff administered the medication on 6/24/25. The resident's clinical record lacked documentation of interventions carried out on 6/24/25 aimed at relieving the resident's pain and lacked documentation of an assessment of the resident's pain. On 6/25/25 at 3:11 p.m., Staff F Registered Nurse(RN) stated if a resident had pain she would like the aides to let her know and they could administer something like Tylenol(acetaminophen) or use a muscle rub. On 6/26/25 at 12:19 p.m., The Assistant Director of Nursing(ADON) stated if Resident #14 complained that her head hurt, staff should respond and offer her Tylenol. The undated facility policy Pain Assessment stated the facility would assure that residents were thoroughly assessed for pain and as comfortable as possible. The policy directed staff to carry out interventions to alleviate pain and discomfort.

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	165570	A. Building B. Wing	06/26/2025

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

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident/family interview and staff interview, the facility failed to ensure residents who were trauma survivors received trauma-informed care to eliminate or mitigate triggers that might have caused re-traumatization of the resident for 2 of 2 sampled residents (Resident #1 and #34) identified by either record review or interview as being a trauma survivor. The facility reported a census of 62 residents. Findings included: 1. The Quarterly Minimum Data Set (MDS) assessment for Resident #1, dated 5/7/25, revealed the resident was admitted [DATE], scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition, had diagnoses of non traumatic brain dysfunction, heart failure, bipolar disorder, asthma and Post Traumatic Stress Disorder (PTSD). Review of the current Care Plan for Resident #1, last revised on 2/20/25, revealed the resident took anti-anxiety and antidepressant medications and was care planned for potential in alterations in psychosocial well-being related depression and anxiety. The Care Plan included non-pharmacological interventions to provide 1:1 reassurance when the resident felt anxious or down and to allow the resident time to answer questions and to verbalize feelings perceptions, and fears. The Care Plan failed to identify the resident was a trauma surveyor and address the resident's PTSD, triggers and interventions. On 06/23/25 at 03:03 PM, Resident #1 reported she had not been invited to attend a care plan meeting since her admit to the facility. On 6/25/25 at 2:50 PM, Resident #1 reported having abandonment and trust issues related to their PTSD. PTSD episodes were triggered when the resident was upset or felt unsafe. The resident reported having had symptoms of nightmares about past trauma and becoming withdrawn when her PTSD was triggered. On 06/25/25 at 12:18 PM, the Assistant Director of Nursing (ADON) reported she had not realized Resident #1 had PTSD and was a trauma survivor until this week when she saw the trigger on the facility matrix (form that included MDS assessment trigger information for residents). The ADON confirmed they had not included trauma-informed care goals or interventions in the care plan. On 06/26/25 at 8:28 AM, Staff N, CNA, reported she worked days and was familiar with Resident #1. She reported not knowing much about the resident being a trauma survivor. On 6/26/25 at 8:33 AM, Staff F, Registered Nurse (RN), reported she would identify trauma survivors by reading through the admission notes and looking for related diagnoses such as PTSD. Staff F was aware of 2 residents that were trauma survivors, and named Resident #34. Staff F was unaware of Resident #1 being a trauma survivor and reported she had not seen Resident #1 display any mental health issues. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 8:42 AM, the Activity Director reported that she relied on the ADON to let her know if a resident was a trauma survivor. The Activity Director explained that if she was aware a resident was a trauma survivor, then she would avoid saying anything that would trigger the resident. The Activity Director was unaware that Resident #1 and Resident #34 were trauma survivors. On 6/26/25 at 11:04 AM, during an interview, Staff A, Licensed Practical Nurse (LPN), confirmed she was the acting social worker for the facility. Staff A reported if a resident was a trauma survivor she would talk with the Medical Director about getting the resident set up with mental health services. Staff A explained that she would talk with the ADON about care planning at the time the resident was admitted . Staff A reported being aware that Resident #34 was a trauma survivor due to talking with the resident's family. Staff A was unaware that Resident #1 was a trauma survivor. Staff A confirmed that she was responsible for completing the BIMS and mood assessments quarterly for Resident #1. Staff A described Resident #1 as a troublemaker and reported the resident had never expressed being traumatized. On 6/26/25 at 2:08 PM, the facility's Advanced Registered Nurse Practitioner (ARNP) reported the main mental health issue for Resident #1 was her PTSD.

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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 clinical record review, policy review, resident/family interview and staff interview, the facility failed to ensure they had sufficient nursing staff to meet the needs of the residents for 3 of 19 sampled residents (Resident #1, #13, and #50). The facility reported a census of 62 residents. Findings included: 1. The MDS assessment for Resident #1, dated 5/7/25, revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition, had diagnoses of non traumatic brain dysfunction, heart failure, bipolar disorder, asthma and Post Traumatic Stress Disorder. The MDS assessment identified the resident required partial to moderate assistance with bathing and personal hygiene. On 6/23/25 at 2:10 PM , Resident #1 explained that the facility had two CNAs working per hall, but there was not enough staff to meet the needs of the residents. Resident #1 reported the facility was always short, but mainly at meals and bath times. Resident #1 reported her shower days were Sundays and Wednesdays. Resident #1 reported that she did not always get her showers two times per week. Resident #1 explained that sometimes the staff were not getting to her shower until 10:00 PM. Resident #1 expressed that this time of night was too late, and she didn't want wet hair at 10:00 at night, so she would refuse her showers at times due to the lateness. Observation of during the interview, revealed the resident to have unkempt hair with a greasy, unwashed appearance. Review of the facility bathing record, titled Resident Cares, for Resident #1, dated February 2025, revealed the resident refused showers on 2/5/25 and 2/16/25 on the 2:00 PM to 10:00 PM shifts. On 2/16/25, Staff C, Certified Nurses Aide (CNA), documented the resident refused the shower and said too late. Review of the facility bathing records, titled Resident Cares, for Resident #1, dated March 2025 through June 2025, revealed the resident refused showers on the 2:00 PM shift to 10:00 PM shift on 3/2/25 and 4/6/25, and refused a shower on the 10:00 PM to 6:00 AM shift on 6/22/25. On 6/24/25 at 3:34 PM, Staff C, CNA, reported she was working 3rd shift (6:00 PM to 6:00 AM) until a couple months ago. Staff C reported Resident #1 normally received her shower on second shift and liked a shower anytime after supper, but before 9:00 PM. Staff C explained that by the time the CNAs got all of the residents out of dining room, the couldn't get to Resident #1's shower until 10:00 PM or 10:30 PM, depending on the night. Staff C reported a couple times they did not enough staff to get all of the residents' showers done. Staff C confirmed Resident #1 had refused a shower a few times due to the lateness. 4. The Payroll Based Journal(PBJ) Staffing Data Report stated the facility triggered for excessively low weekend staffing for the period of 1/1/25 to 3/31/25. The Facility Assessment Tool, updated 5/16/25, stated the facility staffed 4-7 Certified Nursing Assistants(CNAs) on the 1st shift and 4-6 CNAs on the 2nd shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 8:27 a.m. via phone, Staff G CNA stated on the weekends there was absolutely not enough staff to take care of everyone. She stated sometimes they ran with 2-3 CNAs and stated they sometimes had to complete resident showers as late as 10:00 p.m. On 6/26/25 at 12:19 p.m., The Assistant Director of Nursing(ADON) stated staffing was not good in the last five years. She stated she expected staff to respond to call lights within 15 minutes. The undated facility policy Call Light directed staff to respond to call lights to rule out an emergency situations. 3. The Minimum Data Set (MDS), dated [DATE], revealed Resident #50 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Diagnoses included Heart Failure, End Stage Renal Disease (ESRD), Diabetes Mellitus, anxiety disorder, depression, history of malignant neoplasm of bronchus and lung, and history of urinary tract infections. The Care Plan, revised on 6/23/25, revealed Resident #50 had an Activities of Daily Living self-care performance deficit and required extensive assistance of 2 staff for toilet use, transferring, and bed mobility. On 6/24/25 at 10:50 AM, Resident #50 reported it can take an hour for staff to answer her call light when pressed, and identified a digital clock on dresser in which she notes the wait time. Resident #50 stated on 6/23/25 evening she waited an hour and a half to use the restroom when staff told her they would return soon. Resident #50 explained that wait times are longest after an evening meal, when requesting assistance to go to bed. The Care Plan, revised 6/23/25, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Resident #13 frequently had bladder incontinence, required toileting assistance approximately every two hours, and extensive assistance of one staff to transfer between surfaces. The Care Plan listed an intervention to encourage Resident #13 to use the call bell for staff assistance. On 6/23/25 at 1:30 PM, Resident #13 reported frequently waiting up to an hour for help after pressing the call light. Resident #13 stated she would watch a digital clock on the night stand when in the bathroom and a 2nd hand clock on the wall in front of the recliner to monitor for staff response time. Resident #13 stated that recently, unable to recall the date, she waited on the toilet for an hour and four minutes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 2. On 6/26/25 at 11:24 AM, Staff B, Registered Nurse (RN), removed Furosemide and Tramadol from the medication cart and put the medications in a cup with applesauce. Staff B approached Resident #5 with the medications, fed the resident the medications with a bite of applesauce. Staff B then touched the resident's shoulder and returned to the medication cart. Staff B threw away the used medication cup, charted, flipped between the residents' Medication Administration Records (MARs), put applesauce in a cup, opened the medication cart with the keys, removed a medication cassette with Acetaminophen from the cart, dropped two tabs in the cup with applesauce, returned the cassette to the medication cart and locked the cart. Staff B then approached Resident #26, touched the resident's wheelchair on the hand hold area, touched the resident's arm, and fed the resident a bite of applesauce with the medication. Staff B returned to the medication cart, threw away the used medication cup and charted. Staff B flipped through the residents' MARs. Staff B then approached Resident #8 about administering scheduled medications, but the resident refused. Staff B returned to the medication cart, flipped through the residents' MARs and reported that she had no further medications to give until 12:00 PM. Staff B walked away from the medication cart. Staff B failed to perform hand hygiene, either hand washing or an alcohol based hand rub, between residents. An undated facility policy, titled Subcutaneous Injections, included instructions for nursing staff to swab the rubber stopper of the insulin medicine container with an alcohol sponge prior to inserting the syringe in the rubber stopper. An undated facility policy, titled Hand Washing, included instructions for staff to thoroughly wash their hands before and after providing resident care. Based on observation, staff interview, clinical record review, and facility policy review, the facility failed to sanitize the rubber stopper of a multiple-use insulin vial when insulin injection was prepared and administered (Resident #50) and further failed to perform hand hygiene before preparing and between administration of oral medications to multiple residents (Resident #5, #8, and #26) for infection prevention during 2 of 2 medication administration times observed. The facility reported a census of 62 residents. Findings include: The Minimum Data Set (MDS) Assessment, dated 6/05/25, revealed Resident #50 had a diagnosis of Diabetes Mellitus and required insulin injections for 7 of the 7 days review period. The Care Plan, revised on 6/23/25, revealed Resident #50 had diagnosis of Diabetes Mellitus and lacked focus area, goals, or interventions for care needs related to Diabetes Mellitus diagnosis. The June 2025 Medication Administration Record (MAR), revealed an order, initiated on 5/20/25, for Novolog Injection 100 units per milliliter (mL), with instructions to inject 25 units subcutaneously three times a day with meals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 11:20 AM, Staff F, Registered Nurse (RN) removed Resident #50's opened vial of Novolog insulin and a packaged insulin syringe from the medication cart. The insulin syringe was removed from packaging and inserted directly into the rubber stopper of Resident #50's Novolog vial. Staff F removed 25 units of insulin from Novolog vial into the syringe and re-sheathed the needle. When queried, Staff F denied sanitizing the stopper of the vial with alcohol wipe to remove potential pathogens before inserting the syringe into the vial. Staff F proceeded to enter Resident #50's room and administered Novolog insulin injection subcutaneously into the resident's right lower quadrant abdomen. On 6/25/25 at 4:18 PM, the Assistant Director of Nursing (ADON), revealed the expectation of nursing staff to sanitize the rubber of an insulin vial when preparing an insulin syringe for infection prevention. The undated facility policy, titled Subcutaneous Injection, revealed procedure step #9, which instructed staff to swab the rubber stopper of the medication container with an alcohol sponge, prior to inserting the needle into the container.