

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Crystal Heights Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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, and interview, the facility failed to ensure staff provided range of motion (ROM) (joint movement exercises) to maintain functional status and prevent joint contractures (permanent tightening of muscles or joints) for 1 of 2 residents reviewed for restorative care (Resident #37). The facility reported a census of 68 residents. Findings included: Resident #37's MDS assessment dated [DATE] listed diagnoses including cancer (malignant growth), age-related debility (weakness from aging), and adult failure to thrive (decline in physical and cognitive function). Resident #37's MDS documented impairment in ROM on both sides of upper and lower extremities and a Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired cognition. The MDS reflected Resident #37 received Hospice services (end-of-life care) during the lookback period. On 7/16/26 at 8:33 AM observed Resident #37 sitting at the nursing station with his left arm held up tightly to his chest with his left wrist bent downwards at a 90-degree angle. When asked to move the wrist up and down, Resident #37 moved the right wrist, but couldn't move the left wrist. Resident #37's Minimum Data Set (MDS) assessment dated [DATE] documented no impairment in ROM in upper or lower extremities (limbs). Resident #37's MDS assessment dated [DATE] documented no impairment in ROM in upper extremities and impairments on both sides of lower extremities. Resident #37's MDS assessment dated [DATE] documented no impairment in ROM in upper extremities and impairments on both sides of lower extremities. Resident #37's MDS assessment dated [DATE] documented no impairment in ROM in upper extremities and impairments on both sides of lower extremities. Resident #37's MDS assessment dated [DATE] documented impairments in ROM on both sides of upper and lower extremities. A Condition Follow-Up Note dated 12/21/26 documented staff noted a contracture to Resident #37's left arm. Resident #37 held the left arm stiffly in place across the abdomen and chest. Resident #37's record review lacked documentation that completed ROM exercises with him. The Restorative Care policy dated July 2021 instructed the facility to provide each resident restorative care according to individual needs. The policy instructed residents receive services to maintain the highest possible functional status and noted restorative care may include ROM. On 7/15/26 at 2:53 PM Staff E, Certified Nursing Assistant (CNA), stated Resident #37 had a stiff-arm which he could move, but it grew stiffer. Staff E stated the arm got worse. On 7/15/26 at 3:08 PM Staff F, CNA, stated Resident #37's left arm became contracted. Staff F stated the arm felt stiff and Resident #37 could pull the arm out some, but it got worse. Staff F stated no one ever assigned Staff F to complete ROM. On 7/15/26 at 3:28 PM Staff D, CNA, stated working at the facility for 2 years without a restorative program existing at the facility. On 7/15/26 at 4:49 PM Staff A, Therapy Director, stated Hospice would carry out ROM as part of hospice services if Resident #37 received Hospice care. On 7/16/26 at 8:39 AM Staff B, Director of Nursing (DON), stated Resident #37 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 165570	If continuation sheet Page 1 of 8

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff served meals in a timely manner for 7 of 7 residents (Resident #3, Resident #55, Resident #58, Resident #64, Resident #68, Resident #38, and Resident #28) reviewed for meal service. The facility reported a census of 68 residents. Findings included: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of heart failure (heart muscle weakness), non-Alzheimer's dementia (memory loss), and anxiety disorder (excessive worry). Resident #3's MDS listed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. On 7/13/26 at 1:24 PM Staff C, Dietary Aide (DA), delivered Resident #3's lunch to her in her room. 2. Resident #55's MDS assessment tool dated 5/20/26 listed diagnoses including non-Alzheimer's dementia, anxiety disorder, and depression (mood disorder). Resident #55's MDS listed a BIMS score of 15, indicating intact cognition. On 7/13/26 at 12:35 PM Resident #55 stated meals arrived late. 3. Resident #58's MDS assessment tool dated 4/5/26 included diagnoses of depression, high blood pressure (elevated blood pressure), and coronary artery disease (clogged heart arteries). Resident #58's MDS listed a BIMS score of 15, indicating intact cognition. On 7/13/26 at 2:40 PM Resident #58 stated they received lunch that day around 1:30 PM, as usual. The undated facility Mealtimes schedule documented lunch served at 11:30 AM in the Assisted Dining Room and 12:00 PM in the Main Dining Room. The schedule didn't indicate when residents in their rooms received lunches. On 7/13/26 at 3:20 PM Staff D, Dietary Manager (DM), stated staff tried serving room trays before serving the assisted dining room and the main dining room. Staff D stated today wasn't necessarily typical. Staff D stated meal service usually went better than today and tomorrow would go better because they would be present. 4. On 7/13/26 starting at 12:25 PM Resident #64 explained the residents should receive food by 12:30 PM. Resident #64 stated wanting to eat at 12:00 PM, but 12:30 PM was the latest she wanted to eat. Resident #64 stated facility operations felt better organized when she first came compared to now. Resident #64 stated meals usually arrive late and reported she told staff without seeing changes. Resident #64 didn't recall who she told. On 7/13/26 Resident #68 stated meals arrive late sometimes, expressing frustration regarding available options. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/13/26 at 1:00 PM witnessed a staff member served the last meal in the main dining room. On 7/13/26 at 1:11 PM observed a staff member bring out the room tray cart. On 7/13/26 at 1:20 PM Resident #38 said she wished staff would bring food as she was hungry and wanted tea. On 7/13/26 at 1:25 PM Staff C, Dietary Aide (DA), stated one staff member usually passes out room trays while another cleaned the dining room. Staff C denied knowing why the meal delivery took so long that day. On 7/13/26 at 1:28 PM witnessed a staff member took room trays to the North Hallway. On 7/13/26 at 1:33 PM saw a staff member served room trays on the East Hall. On 7/13/26 at 1:35 PM Staff H, Dietary Aide (DA), carried an uncovered food tray to Resident #28's room on the [NAME] Hallway. Staff H stated they needed to get drinks for Resident #28, but didn't pass by again with the drinks. On 7/13/26 at 1:41 PM observed Staff C pass by with the food cart and reported they were done.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, staff, and resident interviews, the facility failed to ensure residents had access to their personal funds in a timely manner for 1 of 1 resident reviewed for personal funds (Resident #55) and for 9 of 9 additional residents who did not have access to their funds for their shopping needs. The facility reported a census of 68 residents. Findings included: 1. Resident #55's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of non-Alzheimer's dementia (memory loss), anxiety disorder (excessive worry), and depression (mood disorder). The MDS listed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. On 7/13/26 at 12:35 PM Resident #55 stated residents lacked access to their money on weekends and she currently waited for items on a shopping list. 2. The Week 1 Resident Shopping List included Resident #55 and 9 additional residents. The Accounts Receivable Policy and Procedure dated 7/7/26 instructed the facility to ensure residents had appropriate access to their funds. On 7/15/26 at 2:09 PM Staff A, Administrative Assistant, stated residents could access their money from 8:00 AM to 4:30 PM on Monday through Friday. Staff A stated they held the only key to the cash box. On 7/15/26 at 3:21 PM Staff B, Activities Assistant, stated she couldn't go shopping the previous week for any residents on the Week 1 Resident Shopping List because she couldn't obtain money from Staff A. On 7/15/26 at 4:57 PM Staff C, Administrator, stated the facility didn't have a plan in place for residents to get money on weekends. Staff C stated moving forward they would place money in the narcotic (controlled medication) box for staff to distribute during off hours. On 7/16/26 at 12:35 PM Staff C stated a breakdown in communication caused staff to not be able to go shopping for residents the previous week. Staff C stated moving forward the staff would go shopping for the residents every Thursday. The previous week, she didn't think money was ready for Staff B to take shopping.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff provided planned activities and supervision for 3 of 3 residents (Resident #17, Resident #20, Resident #19) living on the Memory Care Unit. The facility reported a census of 68 residents. Findings include: Resident #17's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. Resident #17's MDS documented Resident #17 wandered 4 to 6 days out of the 7-day look-back period. Resident #17's MDS documented medical diagnoses for vascular dementia (brain damage affecting memory), unspecified severity, with agitation (restlessness), anxiety disorder (excessive worry), and depression (mood disorder). Resident #17's Care Plan dated 10/17/25 documented a focus area for dependence on staff to meet emotional, intellectual, physical, and social needs related to vascular dementia with behavioral disturbance, hypertension (HTN) (high blood pressure), recurrent depressive disorder (repeated mood depression), severe vascular dementia with agitation, seizure disorder, and epilepsy (seizure disorder). Resident #17 enjoyed walking around the dementia care unit, visiting with others, helping staff with tasks, and visiting with family including a sister who calls on the phone regularly. Care Plan interventions dated 10/17/25 instructed staff to give step-by-step instructions one at a time as needed to support cognitive function, keep routine consistent, and try providing consistent caregivers as much as possible to decrease confusion. On 7/15/26 at 7:55 AM the Memory Care Unit displayed a white board with the date 7/15/26 and the following activities of the day: 10:00 AM: ring toss 1:00 PM: movie 3:00 PM: coffee time On 7/15/26 at 3:12 PM Resident #17 wandered around the common area/TV room in the Memory Care Unit. Staff A, Certified Nursing Assistant (CNA), asked residents what they wanted for drinks and snacks. On 7/15/26 at 3:20 PM Resident #17 walked over to Resident #19, picked up chocolate milk off Resident #19's wheeled walker seat, and started drinking it. Resident #19 tried to tell Resident #17 no, but Resident #17 continued drinking the milk and walked away. No staff remained in the area to observe residents at this time. On 7/15/26 at 3:23 PM staff entered the unit, walked past the common area, and went down the hallway. On 7/15/26 at 3:28 PM Staff A walked into the area, walked into the kitchen area behind the common/TV area for a few seconds, and exited the unit. Resident #20's Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 9, indicating moderately impaired cognition. Resident #20's MDS documented a medical diagnosis for Alzheimer's dementia (progressive brain disease causing memory loss), unspecified. Resident #20's Care Plan dated 8/26/25 documented a focus area for potential activity deficit related to a diagnosis of dementia. Resident #20 stayed active and social participating in activities of choice. Care Plan interventions dated 8/26/25 instructed staff to engage Resident #20 in simple, structured activities such as folders club, live entertainment, and watching TV/movies, provide an activity calendar, and notify Resident #20 of calendar changes. On 7/14/26 at 12:53 PM the Memory Care Unit displayed a white board showing 10:00 AM group exercises, 1:00 PM bird watching, and 3:00 PM coffee time. On 7/14/26 at 2:04 PM Staff A brought a picture to Resident #20 to color. On 7/15/26 at 7:55 AM the Memory Care Unit displayed a white board with the date 7/15/26 and the following activities of the day: 3:00 PM: coffee time On 7/15/26 at 3:10 PM Resident #20 sat in the TV/common room. Staff A asked what Resident #20 wanted to drink or eat. After Staff A supplied drinks and snacks to residents in the area, Staff A left the area. Resident #19's Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 4, indicating severe cognitive impairment. Resident #19's MDS documented a medical diagnosis for Alzheimer's dementia. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19's Care Plan dated 8/26/25 documented a focus area for little or no activity involvement related to Resident #19 wishing not to participate. Care Plan interventions dated 8/26/25 instructed staff to invite Resident #19 to scheduled activities his wife attended to encourage participation. Care Plan interventions dated 4/1/26 indicated the importance of social interaction and leisure activity time. On 7/14/26 at 12:53 PM the Memory Care Unit displayed a white board showing:10:00 AM group exercises1:00 PM bird watching3:00 PM coffee time. On 7/14/26 at 2:04 PM Staff A brought a picture to Resident #20 to color. Staff A asked Resident #19 if Resident #19 wanted to color something, and Resident #19 declined. On 7/15/26 at 7:55 AM the Memory Care Unit displayed a white board with the date 7/15/26 and the following activities of the day:3:00 PM: coffee time On 7/15/26 at 3:20 PM Resident #19 sat in a chair in the TV/common room, ate a snack, and kept chocolate milk on a wheeled walker seat. After Staff A provided snacks and drinks to residents, Staff A left the area. The TV played a show about Elvis. Residents didn't talk among themselves; they sat, ate snacks, and drank drinks. No staff stayed in the area to engage with residents. On 7/15/26 at 2:18 PM Staff B, Activity Assistant, stated conducting the 1:00 PM activity with residents while CNAs conducted morning and afternoon activities with residents in the Memory Care Unit. Staff B stated providing sensory activities, doing programs with Elvis, and taking residents outside when weather didn't feel too hot. Staff B provided a copy of monthly activities for the Memory Care Unit. The July 2026 Activity Calendar for the Memory Care Unit documented activities planned at 10:00 AM, 1:00 PM or 2:00 PM, and 3:00 PM daily. The Activity Calendar documented coffee time every day at 3:00 PM. Beautiful nails scheduled eight times in the month at 10:00 AM. Group exercise planned eight times at 10:00 AM without noted details. The Memory Care Unit housed 10 residents. On 7/15/26 at 3:33 PM Staff D, Certified Nursing Assistant (CNA), stated activities proved a struggle, but having 2 CNAs on the unit now should make tasks easier. Staff D stated Staff B tried coming back to the unit. Staff D stated 3:00 PM coffee time represented snack and drink distribution between lunch and supper. Staff D stated coffee time meant social time, but residents didn't talk to each other. On 7/16/26 at 12:37 PM Staff B stated walking around with Resident #17 and trying to provide squish toys. Staff B stated spending between 30 to 45 minutes a day on the Memory Care Unit depending on arriving fast enough because meals sometimes ran late. Staff B stated Resident #17 and another resident received the first 15 minutes of time Staff B spent on the unit. On 7/16/26 at 12:48 PM Staff C, Assistant Director of Nursing (ADON), stated activity staff went to the Memory Care Unit for 2 or 3 hours a day. When informed interviews showed activity staff didn't spend more than 45 minutes a day in Memory Care, Staff C agreed and confirmed meal times affected the time activity staff spent on the unit. Staff C confirmed the facility could do more and would promote a new program to implement more activities for the Memory Care Unit.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of Quality Assurance and Performance Improvement(QAPI) meeting documentation, policy review, and staff interview, the facility failed to carry out Quality Assurance(QA) activities to obtain feedback, use data, and take action to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting facility-wide processes that impact quality of care, quality of life, and resident safety. The facility reported a census of 68 residents.Findings included:The Quality Assurance and Performance Improvement Policy dated April 2025 instructed facility staff to continually assess facility performance using a systematic, interdisciplinary, comprehensive, and data-driven approach to maintain and improve safety and quality. The Centers for Medicare & Medicaid Services (CMS) Form 2567 dated 6/26/25 listed, in part, the following concerns:F567 related to residents having access to personal fundsF679 related to activity provision Record reviews and interviews conducted from 7/13/26 to 7/16/26 identified the same concerns. On 7/16/26 at 3:56 PM Staff A, Administrator, stated staff didn't discuss personal funds or activities in Quality Assurance (QA). A Performance Improvement Plan (PIP) dated 5/26/26, sent by Staff A on 7/17/26, identified increasing activities in the dementia (memory loss) unit. The PIP documented unit observations of inactivity, increased wandering behaviors, increased falls, and inconsistent participation in structured activities. Objectives included a 25% increase in activities and 1 to 2 hours of daily structured activities offered. Facility records lacked further evaluation of the activity PIP and lacked documentation of QA activities related to resident access to personal funds.		