STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165157	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Pointe Estates Care Center	1400 7th Avenue SE Sioux Center, IA 51250

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 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 interviews, chart and policy review the facility failed to ensure that staff provided adequate and timely assessments and interventions for 1 of 20 residents reviewed. Resident #143 had a fall on the overnight shift, the staff failed to call the doctor and did not reassess the resident until 4 hours later when he was unable to bear weight on the left leg. Resident #142 was sent to the hospital 7 hours after the fall, and was found to have a fractured hip. The facility reported a census of 89 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #143 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit.) At the time of admission, the resident was independent with sit to lying, chair to bed transfer and toilet transfers. The Care Plan updated on [DATE], showed Resident #143 had weakness, impaired balance and congestive heart failure. He used a walker for mobility, was independent with transfers, and toileting. The resident had increased shortness of breath, accompanied with cough, lower extremity edema and staff were to monitor for vital signs and injuries. An Event Report dated [DATE] at 12:15 AM, showed Resident #143 had an unwitnessed fall in his room. He was found lying on his left side and told the staff that he got dizzy. He did not remember if he had hit his head or not. His initial blood pressure after the fall was 105/55. The resident complained of pain in his left leg, was given Tylenol and transferred back into the recliner. A document titled: Neuro Checks for Resident #143, showed that on [DATE] at 1:13 AM, the pupil reaction was brisk, pupil shape was round, eye movement, tracking and peripheral visual fields were intact. A follow up neuro checks at 4:15 AM, showed the same eye assessment responses and then indicated that the resident was sleeping. The chart lacked vitals during this assessment. On [DATE] at 12:27 PM, Staff D, Registered Nurse (RN) said that she worked the morning shift on [DATE] and got report from the overnight nurse. The nurse told her that Resident #143 had a fall and he was having hip pain. Staff D went and assessed the resident and when she assessed the range of motion on his left leg, the resident yelled out in pain. Staff D then called the doctor and had the resident sent to the hospital. She told the overnight nurse that if there was any suspected fracture, or if the resident was having pain, staff should have called the on-call doctor for guidance. According to the Vitals tab in the electronic chart on [DATE] at 6:20 AM, Resident #143 had a blood pressure of 83/45. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Emergency Department Note dated [DATE] at 7:10 AM, showed that the resident had a closed intertrochanteric fracture of left hip and hypotension. The patient had been struggling with worsening of his heart failure and dyspnea on exertion. He'd had a drastic decline since moving to nursing home. The resident was admitted to the hospital for possible surgery. The Hospital History and Physical dated [DATE] at 2:16 PM, showed the Assessment and Plan indicated Resident #143 had sepsis, hypotension, and a closed intertrochanteric fracture of left hip. On [DATE] at 3:48 PM, the hospital report showed Resident #143 was critically ill with worsening hypoxemia (low oxygen) hyperkalemic (high potassium) and was in rapid deterioration. He was sent to the Intensive Care Unit and expired on [DATE] at 8:28 AM. On [DATE] at 10:44 AM, Staff G, Registered Nurse (RN) said that on the overnight shift of [DATE], Resident #143 woke up and tried to go to bathroom and fell. The Certified Nurse Aide (CNA) found him on the floor and the two of them transferred him back into the recliner. Staff G said that he checked the Range of Motion (ROM) of his legs and he was moving them but the left one was painful. Staff G administered some Tylenol and the resident said he was feeling okay. Staff G said that they kept checking on him throughout the night and he continued to have some pain. Staff G said that he tried to call the Director of Nursing (DON) at the time but the call didn't go through. He said that he did not contact doctor by phone, but sent a fax. It was his understanding that if it was after 11:00 PM, unless there was an emergency, the morning nurse would contact the family. On [DATE] at 9:28 AM, Staff F, CNA, said that Resident #143 was getting up to go to the bathroom by himself and ended up falling backwards. She and Staff G went in when they heard a thud, the nurse assessed him and they transferred him back into the recliner. The resident said that he was having leg pain so the nurse gave him something. Staff F said that she checked on him throughout the night and around 4:00 AM, he said he had more pain. She and Staff G tried to get him up to clean him because he was wet, but the resident could not stand because he had too much pain in the left leg at that time. According to a summary of a conversation between the DON and Staff G, the DON asked the nurse why he hadn't sent the resident to the hospital when he was unable to bear weight. Staff G was then educated that when a resident had decreased ROM, and unable to bear weight, staff should call the emergency room doctor, and call the family. According to the policy titled: Falls Follow up Documentation last review 8/2024, for an unwitnessed fall or fall with suspected heard injury, staff would complete vital signs and neurologic checks to be done at the time of the fall, then neuro checks every 4 hours x 24 hours then each shift x48 hours. Vital signs were to be obtained every shift x72 hours. On [DATE] at 11:15 AM, the DON and the Administrator agreed that the overnight nurse should have called the doctor and the family sooner. When asked about the falls follow up policy, and standards of care for vitals and neuro checks after unwitnessed falls, they said that policy had been in place for a while but they would revisit it to see if they needed to make any changes.

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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 interview, record and policy review the facility failed to use proper safety equipment to ensure safe transfers and ambulation for 1 of 3 residents reviewed. Resident #38 had a change in status with increased weakness, and fell at 4:40 AM on 5/17/25. Later that morning, staff failed to use a gait belt while assisting the resident with ambulation and transfers, and the resident had another fall. The facility reported a census of 89 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #38 had a Brief Interview for Mental Status score of 15 (intact cognitive ability.) She was independent with toileting, dressing, walking and transferring. The Care Plan updated on 1/21/25, showed Resident #38 had pain related to a fracture, and ovarian cancer. She was independent with transfers and ambulation with the use of a walker. The resident was admitted to Hospice on 4/14/25. On 5/17/25 she had an unwitnessed fall in the bathroom, and was reminded to use her call light for assistance. After a second fall on 5/17/25, staff attached a sign to her walker to call for assistance, and staff were instructed to use a gait belt and keep her oxygen in place. An Incident Report dated 5/17/25 at 4:40 AM, showed Resident #38 was a high risk for falls and she was found on the floor after attempting to go to the bathroom. She was supine with feet facing the bathroom door and her walker was in front of her near her feet. The resident had been very confused throughout the night and had not slept, and many times she attempted to get out of her recliner. She had an acute change in mental status. The Incident Report dated 5/17/25 at 9:45 AM, showed Resident #38 was assisted back to her room from dining room following breakfast. Her gait was unsteady and she fell backwards. All staff were made aware of change to ambulation assist of one with gait belt and walker in room. The aide had momentarily let go of the resident to straighten pad on the chair, that's when she fell. Due to new confusion and fall earlier in day, staff had been educated on the increased fall risk. On 6/25/25 at 12:00 PM, Staff H, Registered Nurse (RN) said that the night shift reported Resident #38 had a fall earlier that morning and was more confused. Staff H was checking very frequently. Resident #38 eventually wanted to come out to the dining room. She said she asked Staff I to assist the resident back to her room. When they were in the room getting ready to sit down Staff I reached down to adjust something in the chair, and turned from her. That was when she fell. The med aide was not using a gait belt and the staff had been directed to monitor her closely. On 6/25/25 at 11:09 AM Staff I Certified Medication Aide (CMA) said it had been passed on in morning report that Resident #38 had been very weak that morning. She came out for breakfast and Staff I helped her walk to the table for breakfast. She walked her back to her room. They got to the room, and the resident leaned over to straighten the cushion in her chair before sitting. Staff I said that she would do it for her and momentarily let go of the resident and turned away from her. That's when she fell. The resident had her walker in front of her and was holding onto the handle with one hand. Staff I said she was holding onto the back of her pants and did not use a gait belt. After that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall, the resident was instructed to call for assistance, and they tried to keep eye on her. She said that they had discussed with the nurse that morning that the resident had a change in status and needed close monitoring. On 6/26/25 at 11:15 AM the Director of Nursing and Administrator agreed that Resident #38 had a change in status and staff should have used a gait belt while assisting with ambulation and transfers. According to a facility policy titled: Gait Belt Usage, last reviewed 9/2024 showed that gait belts would be used by all employees with any resident and/or patient who needed assistance with ambulating and/or transferring.