STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165290	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Crest Living Center	34 Northcrest Drive Council Bluffs, IA 51503

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review, document review, Medication Administration Record - Treatment Administration Record (MAR-TAR), staff interview and policy review the facility failed to notify the primary care physician with the resident's lab results from a Urine Analysis (UA) for 1 of 3 residents (Residents #1) reviewed. The facility reported a census of 57 residents.Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. The MDS documented utilization of indwelling catheter.Review of Resident #1's EHR titled, Orders documented a physician's order started 8/11/25 to change indwelling catheter with 22 French on the 11th of the month. EHR titled, Orders also documented a physician's order to obtain UA and send out one time only for 1 day dated 6/6/25.Review of Resident #1's EHR titled, Orders documented a physician's order started 7/29/25 to change indwelling catheter with 22 French as needed related to obstructive and reflux uropathy.Review of Resident #1's EHR titled, Progress Report documented on 8/6/25 at 7:08 AM a new order to obtain and send out UA d/t aggressive behaviors with orders added to EHR. EHR titled, Progress Report documented on 8/6/25 at 9:38 PM UA was obtained and taken to the lab at that time.Review of Resident #1's document with fax date of 8/7/25 titled, Urinalysis Results documented bacteria 4+, red blood cells 51-100 with reference range of 0-2, white blood cells 3-5 with reference range of 0-2, urine appearance of turbid with reference range of clear, ph urine greater than or equal to 9 with reference range of 5-8, leukocyte esterase urine large with reference range of negative, protein 300 with reference range of negative, ketones trace with reference range of negative and blood in urine moderate with reference range of negative. UA also documented a culture to follow. Review of UA documented no review from nursing staff and no physician notification.Review of Resident #1's document with fax date of 8/9/25 titled, Bacteria Culture Results documented Preliminary report of greater than 100,00 CFU/mL proteus mirabilis and greater than 100,00 CFU/mL gram negative rod with antibiotic susceptibility. Review of Bacteria Culture Results documented no review from nursing staff and no physician notification.Review of Resident #1's EHR titled, Progress Notes documented no reception of faxes on 8/7/25 or 8/9/25. Further review of EHR titled, Progress Notes documented no notification to Resident #1's physician of either fax results.Review of Resident #1's EHR titled, Progress Notes documented on 8/18/25 Staff B, Medical Doctor (MD) / Primary Care Physician for Resident #1 was notified of Resident #1's hospitalization with admission to the hospital for acute respiratory failure related to sepsis secondary to urinary tract infection.On 8/26/25 at 8:47 AM Staff A, Registered Nurse (RN) acknowledged she was the charge nurse on 8/7/25. Staff A stated once the lab results are sent back to the facility the charge nurse would receive the lab results. Staff A explained when there was a nurse for the memory hall and a nurse working the park hall it was the facility's expectation that the charge nurse would take care of lab results faxed to the facility. Staff A stated the lab (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results were sent back through the fax machine but now it is her understanding it is sent through an email. Staff A acknowledged she was still figuring out the processes at the facility. Staff A stated everything that she received and processed she signed when she processes them. Staff A stated she had not received the faxed UA for Resident #1 on 8/7/25. On 8/26/25 at 9:00 AM Staff B, MD stated the main cause of hospitalization for Resident #1 was due to respiratory failure due to aspiration and does not believe knowledge of the lab or starting antibiotics would have prevented the hospitalization. Staff B, MD explained the results of the UA and Bacteria Culture Results should have been sent to him, that was a professional standard. Review of the email dated 8/22/25 from Staff C, Medical Records Staff to the DON documented Staff C understood she was a part of the fail safe for lab results processing. Results with no signatures get printed out and given to the nurses.On 8/26/25 at 8:31 AM the Director of Nursing (DON) acknowledged she could not find when the lab results were sent to the physician once received by the facility from the lab. The DON stated as the results come back from the lab the results should be sent off to the doctor for review. The DON stated she had noticed the missed physician notification on 8/22/25 and started educating the nurses at the facility about physician notification and handling of lab results. The DON stated she had updated the nurses on the follow up portions for the lab results to the physician. The DON explained it was a situation that warranted a mass audit to be sure nothing was missed in the process. Review of policy updated 9/24 titled, Physician Order Guideline documented it was the policy of the facility to secure physician orders for care and services for residents as required by state and federal law. Physician orders will be dated and signed according to state and federal guidelines. Unclear or incomplete written orders will be reviewed with the physician. Any order clarification will be documented on the physician's telephone order form. Faxed orders will be accepted under the following conditions: the physician signs and retains the original copy of the faxed order and the physician provides the original copy, if requested.Review of document updated 8/22/25 titled, Labs documented when lab results are received the receiving nurse was to send to the physician and update the awaiting physician section.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, Medication Administration Record - Treatment Administration Record (MAR-TAR) review, policy review and staff interviews the facility failed to provide appropriate interventions for the urinary catheter to provide appropriate services to prevent urinary tract infections to 1 of 3 residents reviewed (Resident #1). The facility reported a census of 57 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS documented utilization of an indwelling catheter.Review of Resident #1's EHR titled, Orders documented a physician's order dated 7/29/25 to flush the indwelling catheter as needed for clogging / dysfunction as needed with 30-60mL sterile water.Review of Resident #1's MAR-TAR documented a physician's order with a start date of 7/29/25 to flush the indwelling catheter as needed for clogging / dysfunction with 30-60mL sterile water. Review of Resident #1's MAR-TAR documented no utilization of the as needed catheter flush for the month of August.Review of Resident #1's EHR titled, Progress Notes documented no utilization of the as needed catheter flush for the month of August.Review of Residents #1's EHR titled, Task B&B-Catheter Care from 8/6/25 through 8/17/25 documented Resident #1's output each shift of less than or equal to 100mL on 8/6/25 at 8:36 PM of 100mL, 8/9/25 at 7:58 AM of 100mL, 8/10/25 9:59 PM of 50mL, 8/11/25 at 7:59 PM of 100mL, 8/14/25 at 8:47 PM of 0cc, 8/16/25 at 8:42 PM of 0cc, 8/17/25 at 5:32 AM of 0cc and 8/17/25 at 8:48 PM of 0cc.Review of Resident #1's EHR titled, Progress Notes documented on 8/18/25 Staff B, Medical Doctor (MD) / Primary Care Physician for Resident #1 was notified of Resident #1's hospitalization with admission to the hospital for acute respiratory failure related to sepsis secondary to urinary tract infection.On 8/26/25 at 2:45 PM Staff D, Physician's Assistant (PA) for Resident #1's Urologist stated if Resident #1 had 100mL or less per 8 hour shift the expectation was a catheter flush and if needed a catheter change would have been completed. Staff D stated if the catheter was leaking and wet briefs were noticed a flush should have been completed. Staff D explained that less than 100mL or no output could indicate the catheter was clogged or there was some dysfunction. On 8/26/25 at 1:58 PM Staff E, Registered Nurse (RN) stated if Resident #1 had bladder spasms or the urine was coming out of the penis, if there was discoloration, sediment or with decrease in output an as needed flush should be completed . Staff E stated if Resident #1 had 0mL output from his catheter; she would utilize the PRN flush. Staff E stated if 100mL was a decrease for Resident #1 she would flush his catheter. On 8/26/25 at 2:16 PM Staff F, Licensed Practical Nurse (LPN) acknowledged she had worked with Resident #1. Staff F stated she would use the as needed flush if Resident #1 had only 100mL and Resident #1 usually had 200mL. Staff F stated if there was decrease in output or there was no output she would utilize the as needed catheter flush. Staff F stated if there was no output for a shift Resident #1 would require a flush. Staff F acknowledged 100mL would also require a flush. Staff F explained if the as needed flush order was utilized it would be signed off in the MAR-TAR and a Progress Note would be entered. On 8/26/25 at 3:12 PM Staff G, LPN explained if she worked a shift and Resident #1 had no output she would have utilized the as needed flush order. Staff G stated if there is 100mL on days and 50mL on the pm shift Resident #1 would require a flush. Staff G explained the catheter should have been flushed when 100mL or less per shift. On 8/26/25 at 11:51 AM the DON stated the Certified Nursing Assistant (CNA) should be letting the nurse know with little to no output from any resident. The DON explained the flushing should be utilized at the nurses discretion. The DON acknowledged if the output was 50cc then the nurse should have investigated the output further. She (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she felt like the concern was a documentation issue. The DON stated if there was a decrease in output the nurse should have been notified. The DON acknowledged no output from Resident #1's catheter could indicate dysfunction or the catheter was clogged.Review of policy updated 10/24 titled, Catheters documented the policy was to provide guidance in the preventive measures for controlling common infections for residents with a urinary catheter as part of the overall infection control policy. The facility was committed to providing a safe and healthy environment for residents and to minimize or prevent the spread of infection. Catheters are to be changed per orders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview the facility failed to provide appropriate infection prevention practices when providing care to a resident with a catheter, that was on Enhanced Barrier Precautions (EBP) for 1 of 3 reviewed (Resident #3). The facility reported a census of 57 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documented utilization of an indwelling catheter.Review of Resident #3's EHR titled, Orders documented a physician's order started 8/4/25 to change indwelling catheter with 16 French monthly and as needed. Review of Resident #1's EHR titled, Orders documented a physician's order started 7/29/25 to change indwelling catheter with 16 French monthly and as needed. Observation on 8/25/25 at 3:10 PM of catheter care completed on Resident #3 by Staff H, Certified Nursing Assistant (CNA) and Staff I, CNA with EBP signage posted in Resident #3's room revealed Staff H present in the room with Resident #3 sitting on the commode. Staff H left the room and asked another staff member to help with peri care. Staff H returned to Resident #3's room with Staff I. Staff H and Staff I applied gloves, neither staff completed hand hygiene or applied a gown, Staff H utilized a gait belt to assist Resident #3 with standing, Staff I obtained wipes, Staff I removed peri wipes from the bag, cleansed catheter and penis while standing behind Resident #3, cleansed buttocks with 2 peri wipes, pulled Resident #3's brief up, pulled Resident #3's pants up, Staff H assisted Resident #3 with transfer to the wheelchair, Staff H removed gloves, Staff H completed hand hygiene, Staff I removed gloves, Staff I gathered trash in trash bag, Staff I removed the trash bag, Staff I exited Resident #3's room, Staff I walked down the hall to the soiled utility room, Staff I opened the door, placed garbage in the trash barrel and Staff I completed hand hygiene in the hall outside the soiled utility room. On 8/25/25 at 3:30 PM Staff H stated he was not required to wear a gown when Resident #3 was on the commode. Staff H stated when he was not working directly with the bodily fluids the gown would not be expected. Staff H acknowledged that other CNA was not wearing the gown at the time of catheter care and peri care. Staff H explained Resident #3 was having a BM there is no expectation for gown application. Staff H stated with Enhanced Barrier Precautions (EBP) he was supposed to gown and glove for catheter and peri cares but not required when Resident #3 was having a bowel movement. On 8/25/25 at 3:56 PM Staff I, stated the only time she would apply a gown was when she emptied Resident #3's catheter. On 8/25/25 at 4:05 PM the DON stated the facility's expectation was that gowns would be worn by the staff that transferred the resident and the staff completing care on the resident. On 8/26/25 at 2:16 PM Staff F, Licensed Practical Nurse (LPN) stated when there was any care provided to a resident with catheters the staff are required to wear a gown, gloves and complete hand hygiene before and after application of gloves or resident contact. On 8/26/25 at 4:17 PM the DON stated hand hygiene should be completed prior to resident care, after resident care, before applying gloves and after removal of gloves. The DON stated the staff should have worn gowns with the resident cares on Resident #3. Review of policy updated 11/24 titled, Enhanced Barrier Precautions (EBP) documented EBP was used to prevent the spread of Multi-Drug Resistant Organisms (MDRO) to residents. EBP precautions apply when a resident is not known to be infected or is known to be infected with a CDC-targeted MDRO and has a wound or indwelling medical device. Indwelling medical devices include urinary catheters.Review of policy updated 8/24 titled, Hand Hygiene documented hand hygiene will be completed before anticipated contact with resident, after contact with a resident, after contact with blood, body fluids, visibly contaminated surfaces, after contact with objects in the residents room, after removing Personal Protective Equipment (PPE).