STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165302	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of New Hampton	530 South Linn Avenue New Hampton, IA 50659

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and staff interview the facility failed to follow the Care Plan for 1 of 3 residents reviewed (Resident #1). The facility identified a census of 42 residents. Findings include: A Care Plan for Resident #1 directed the facility staff the resident required the following Focus and Intervention areas as dated: a. An activities of daily living (ADL) self-care deficit related to (r/t) a stroke, type II Diabetes Mellitus, peg tube (gastrostomy tube), low vision in both eyes, obesity, hemiplegia on his left side (paralyzed), and respiratory failure. (initiated 1.15.25 and revised 4.11.25). 1. Dependent on two (2) staff members with bed mobility. (initiated 1.15.25 and revised 4.11.25) b. Impaired cognition r/t a Cerebral Infarct (stroke). The resident suffered from an inability to verbalize. (initiated 1.10.25 and revised 4.30.25) c. At risk for falls r/t a stroke, psychotropic medication use, hemiplegia, immobility, poor vision in both eyes, and obesity. (initiated 1.15.25 and revised 5.13.25) 1. Bed in lowest position when positioned in bed. (initiated 5.5.25) 2. Utilized a body pillow when repositioned. (initiated and revised 4.22.25) 3. Notification of the resident, family, and care givers of any new areas of skin breakdown. (initiated 1.15.25 and revised 4.30.25) According to a Progress Note entry dated 6.3.2025 at 8:50 p.m. the resident had been found on the floor beside his bed and sustained an abrasion to his right knee that measured 4 cm x 2 cm. The new intervention directed the facility staff to have performed 2 hour staff checks when they walked past his room. During an interview 6.4.25 at 12:45 p.m. Staff C, Licensed Practical Nurse (LPN) confirmed when she received report that morning the night shift staff informed her of the fall but failed to inform her of the abrasion to the resident's left knee or the every 2 hour staff walk by his room checks. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a Progress Note entry dated 5.2.2025 at 2:29 p.m. the nurse walked into the resident's room and found the residents' bed in a high position and the resident positioned on the floor on the left side of his bed, towards the window and on his hands and knees. The resident sustained an abrasion (superficial open areas) to both his knees. During an interview 6.4.25 at 11:15 a.m. Staff C, LPN confirmed the resident's bed as not positioned all of the way to the floor prior to his fall on 5.2.25. During an interview 6.4.25 at 10:50 a.m. Staff A, Certified Nursing Assistant (CNA) confirmed she worked 5.2.25 and when she entered the resident's room she found him positioned on the floor on all fours and the bed not in it's lowest position. The staff member confirmed staff should have absolutely followed each individual resident's Care Plan. According to an email 6.4.23 at 10:33 a.m. the Administrator confirmed she expected staff to have followed the individual resident's Care Plans.

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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 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. Based on clinical record review, staff interview, and facility policy review, the facility failed to properly assess and intervene for 1 of 3 residents following a fall. (Resident #1) The facility identified a census of 42 residents. Findings include: During an interview 6.4.25 at 12:45 p.m. Staff C, Licensed Practical Nurse (LPN) indicated she received report the resident had fallen last night (6.3.25) but there had been no report of an abrasion to Resident #1 knees. The staff member felt the fall occurred yesterday afternoon but on this day, sometime after 8 a.m., the Director of Nursing (DON) came to her and asked where the Incident Report had been located and Staff C told her she did not know as the Incident Report had not been in Point Click Care (PCC) at 5:45 a.m. During an interview 6.5.25 at 11:27 a.m. Staff D, LPN was aware Staff E, LPN documented her assessment in the Progress Notes around the 8 p.m. hour but failed to complete an Incident Report per facility policy. Staff D confirmed Staff E reported the abrasion located on the resident's right knee but not the intervention of staff to have walked by the resident's room every two (2) hours. Staff D also indicated she thought Staff E conducted four (4) sets of vitals but had not performed neurological (neuro) checks as she started the neuro sheet when she arrived at work. The staff member felt there had been times staff could have provided a more thorough report to oncoming staff members. A Neurological Assessment form dated 6.3.25 at 8:50 p.m. revealed nursing staff failed to assess the resident's neuro's as follows: a. Every 15 minutes times (x) three (3) immediately post the resident's fall. b. Every four (4) hours x one (1). c. Every eight (8) hours x 1. An observation 6.4.25 at 9:50 a.m. revealed a non-dated or initialed band aide on the right knee of Resident #1 with noted dark shadowing under the dressing with the appearance of sanguineous (bloody) drainage. Clinical record review 6.4.25 at 12:05 p.m. revealed no treatment to either knee. An observation 6.4.25 at 12 p.m. revealed the Director of Nursing (DON) as she removed the bandage with sanguineous drainage that covered the pad portion of the bandage itself. The open area to the knee appeared the size of a .50 cent piece. According to an email 6.4.25 at 2:21 p.m. the Administrator confirmed she expected staff to have completed an Incident Report form immediately post a fall. The Administrator indicated the nurse on duty during the fall had been newer and had not dealt with a fall so education had been provided that morning (6.4.25) when staff called her back into the facility to complete the form as expected. A Risk Management form updated 9.27.24 included the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Neurological assessments must have been completed with every unwitnessed fall or/or possible head injury. b. All Incident Reports to be completed by the end of a nurses scheduled shift.