

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of New Hampton		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident interview, staff interview, and facility policy review the facility failed to maintain comfortable room temperatures and interventions to maintain resident comfort levels during a heating mechanism malfunction that lasted for an extended period of time for 5 of 5 residents reviewed (Resident #1, #2, #3, #5, and #6). The facility identified a census of 31 residents. Findings include: On 12/4/25 at 3:15 p.m., Resident #1 indicated he resided at the facility for two years and the facility dealt with heating/cooling issues about every six months. In this case, the system acted up for 1.5 weeks prior to Thanksgiving when it really felt cold. The resident indicated yesterday had been the first day the facility staff offered him to change rooms because his room lacked heat. The resident confirmed he would have moved sooner if offered because he felt cold. The resident indicated the facility offered more blankets, he had to ask for coffee/tea, the facility checked the temperatures in his room but never his body temperature. The resident verbalized concern for those residents that could not speak for themselves and how they felt with no heat. During an interview 12/4/25 at approximately 12:45 p.m., Resident #2, identified as not interviewable by the facility, confirmed it had been cold in the facility the past week and staff gave him extra blankets but he still felt cold. On 12/4/25 at 2:55 p.m., Resident #2 confirmed staff only asked him yesterday if he wanted to move to a different room which he refused. During that time the resident indicated the heat malfunctioned and he felt cold, even with blankets, and facility staff failed to offer him warm drinks. During an interview 12/4/25 at 3:35 p.m. Resident #3 confirmed it had been cold in the facility for the past week or so and it had not been until the last evening the facility repaired the heat. The resident indicated during the time the heat malfunctioned the facility staff placed space heaters in the hallways and gave residents more blankets but failed to offer warm/hot drinks and even with those interventions the resident remained cold. The resident confirmed the first time staff asked him if he wanted to change rooms to the warm area of the facility had been yesterday and he agreed however he would have moved sooner. During an interview 12/4/25 at 3:45 p.m., Staff A, [NAME] indicated the facility always provided coffee, tea, warm water, etc. to any resident who asked. However, they failed to set up an additional station for availability of said items to all residents at any time. During an interview 12/4/25 at 4:09 p.m., Staff B, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) confirmed she worked when the heat became nonfunctional and the temperatures in occupied resident rooms ran between 50 or 60 degrees, as noted from thermometers in the individual resident rooms. The staff member confirmed most of the resident complained of the cold. Staff gave residents more blankets but only moved residents that asked. The staff member confirmed staff only offered resident hot drinks during meals. During an interview 12/5/25 at 1 p.m., Staff C, CNA/CMA indicated she recalled an unknown occupied resident room temped out at 60 degrees F when the furnace broke. The staff member confirmed residents complained of the cold but no hot drinks were offered during that time span. During a tour and interview 12/4/25 at 12:45 p.m. Staff D, Maintenance Supervisor indicated the delay in the heating unit repair had been corporate approval as the situation entailed the circulation pump for hallways 100 and 300, which started to act up. Staff D further described the unit made noises on Wednesday, 11/26/25. On Thursday (Thanksgiving), himself and a local plumbing and heating repair person attempted to repair the system, however it only lasted three hours. The staff member indicated the heating system remained non-functional in the affected areas until 12/3/25. Staff D indicated the other staff moved the affected residents into the heated area of the facility, placed fans along with radiator type portable heaters in the hallways, increased the heating temperatures in the common areas and the hallways with heat (the 200 and 400 hallways) and the dining room. The tour continued as Staff D took the current temperatures in the resident rooms as identified below: room [ROOM NUMBER] = 65.8 F (room not in working order at current time) room [ROOM NUMBER] - 64.7 F on the window wall with room occupied by Resident #5. The resident indicated she felt cold a little bit, but better than the other day. The inside wall registered 70.1 F on inside wall where thermostat had been is located. room [ROOM NUMBER] - 62.8 F outside wall by window with the room occupied by Resident #6. The inside wall 72.7 F. The resident reported it had been very cold through the weekend but the facility offered blankets. Staff D indicated resident room should have stayed around 70 degrees F. On 12/4/25 at 1:32 p.m. Staff D indicated the facility had already started the process of corporate approval the week prior on the 18th, when the heating pump downstairs started making a noise and leaked, but remained functional. Review of the facilities Loss Of Heating System policy and procedure updated</p>		