STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165420	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Traditions Memory Care of Newton	2130 West 18th Street South Newton, IA 50208

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, and staff interviews, the facility failed to develop effective care plan interventions protect the resident's right to be free from physical abuse for 4 of 7 residents reviewed for resident to resident altercations(Residents #2, #5, #6, #7). The facility reported a census of 46 residents.Findings included: 1. The Minimum Data Set(MDS) assessment tool, dated 8/4/25, listed diagnoses for Resident #1 which included psychotic disorder(a mental health condition characterized by a loss of touch with reality, leading to significant disturbances in thoughts, perceptions, and behavior), schizophrenia(a chronic mental health condition characterized by a combination of symptoms that can significantly impact a person's thoughts, feelings, and behavior), and anxiety disorder. The MDS stated the resident was independent with walking and had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) which occurred 4 to 6 days out of the 7 day review period. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 0, indicating severely impaired cognition. The facility Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy updated 10/19/22, stated residents must not be subjected to abuse by anyone including other residents. The policy defined dependent adult abuse to include assault of a dependent adult, which meant the commission of any act which was generally intended to cause pain or injury to a dependent adult, or which was generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which was intended to place another in fear of immediate physical contact which would be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act.Care Plan entries, dated 7/31/25, directed staff to provide reassurance and consult psychiatric services as needed, change rooms if indicated, assess for contributing factors, and move to a quiet area to deescalate behavior.An 8/1/25 Care Plan entry directed staff to carry out non-pharmacological interventions such as offers of food, fluids, toileting, activities, family calls, pain assessments, repositioning, and one on one staff supervision. An 8/14/25 Care Plan entry directed staff to redirect the resident out of other resident rooms.An 8/29/25 Care Plan entry stated the resident relaxed and rested when she cuddled with staff.A 9/1/25 Care Plan entry stated the resident was one on one with staff as needed for safety while she ambulated.The Care Plan lacked interventions shown to be effective in preventing the resident from physical aggression with other residents.A 4/24/25 hospital Provider Progress Note stated the resident was involuntarily discharged from her nursing home and stated in the Emergency Department, she was very aggressive, hit staff, and required multiple security guards.A 7/28/25 admission Summary stated the resident admitted to the facility. A 7/28/25 Health Status Note stated the resident wandered all shift and went in and out of other's rooms, crawled in bed with them, and sat in occupied chairs. A 7/30/25 Health Status Note stated the resident continuously wandered and entered peer rooms, upsetting them.An 8/2/25 Health Status Note stated the resident wandered, trespassed, and took peer belongings. She attempted to get into bed or sit in a chair with others which caused peer agitation. She was aggressive and combative and had two incidents of increased agitation with peers. She attempted to sit on a male peer's lap and attempted to kiss another male peer on the mouth.A 9/27/25 Health Status Note stated the resident told staff she would hit them and slapped a staff member on the back.A 10/5/25 Health Status Note stated the resident had an increase in her behaviors. She was mean and took her peer's meals away from them. She grabbed food off their plates and cursed at them. She hit, kicked, and bit when anyone tried to redirect her. Her morphine(a narcotic pain reliever) and Haldol(an antipsychotic medication) had zero effectiveness. A 10/13/25 Health Status Note stated each day the resident became more aggressive with staff, peers, and even guests. She had no boundaries and called names, hit, kicked, and grabbed other's food. She was not redirectable and it required two staff to attempt to take care of her. A 10/14/25 Health Status Note stated the resident had multiple medication changes without benefit. The resident continued to wander into other's rooms, grabbed their belongings, and caused irritation to other residents. She swore at staff and called them [NAME] and vulgar names. She told them to die and to go to hell. She hit a staff member which caused a bruise and skin tear to the staff member. Her medication regimen changes were completely ineffective regardless if they were scheduled or as needed(prn). A 10/21/25 Health Status Note stated the resident was agitated after dinner and repeatedly went in and out of resident rooms. Staff carried out 1:1 supervision with

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, and staff interview, the facility failed to provide adequate supervision to protect the resident's right to be free from physical abuse for 4 of 7 residents reviewed for resident -to-resident altercations (Residents #2, #5, #6, #7). The facility reported a census of 46 residents. Findings include:1. The Minimum Data Set (MDS) assessment tool, dated 8/4/25, listed diagnoses for Resident #1 which included psychotic disorder (a mental health condition characterized by a loss of touch with reality, leading to significant disturbances in thoughts, perceptions, and behavior), schizophrenia (a chronic mental health condition characterized by a combination of symptoms that can significantly impact a person's thoughts, feelings, and behavior), and anxiety disorder. The MDS stated the resident was independent with walking and had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) which occurred 4 to 6 days out of the 7-day review period. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 0 out of 0, indicating severely impaired cognition. The facility Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy updated 10/19/22, stated residents must not be subjected to abuse by anyone including other residents. The policy defined dependent adult abuse to include assault of a dependent adult, which meant the commission of any act which was generally intended to cause pain or injury to a dependent adult, or which was generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which was intended to place another in fear of immediate physical contact which would be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act. Care Plan entries, dated 7/31/25, directed staff to provide reassurance and consult psychiatric services as needed, change rooms if indicated, assess for contributing factors, and move to a quiet area to deescalate behavior.An 8/1/25 Care Plan entry directed staff to carry out non-pharmacological interventions such as offers of food, fluids, toileting, activities, family calls, pain assessments, repositioning, and one on one staff supervision. An 8/14/25 Care Plan entry directed staff to redirect the resident out of other resident rooms.An 8/29/25 Care Plan entry stated the resident relaxed and rested when she cuddled with staff.A 9/1/25 Care Plan entry stated the resident was one on one with staff as needed for safety while she ambulated. A 4/24/25 hospital Provider Progress Note stated the resident was involuntarily discharged from her nursing home and stated in the Emergency Department, she was very aggressive, hit staff, and required multiple security guards. A 7/28/25 admission Summary stated the resident admitted to the facility. A 7/28/25 Health Status Note stated the resident wandered all shift and went in and out of other's rooms, crawled in bed with them, and sat in occupied chairs. A 7/30/25 Health Status Note stated the resident continuously wandered and entered peer rooms, upsetting them. An 8/2/25 Health Status Note stated the resident wandered, trespassed, and took peer belongings. 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She was not redirectable and it required two staff to attempt to take care of her. A 10/14/25 Health Status Note stated the resident had multiple medication changes without benefit. The resident continued to wander into other's rooms, grabbed their belongings, and caused irritation to other residents. She swore at staff and called them [NAME] and vulgar names. She told them to die and to go to hell. She hit a staff member which caused a bruise and skin tear to the staff member. Her medication regimen changes were completely ineffective regardless if they were scheduled or as needed(prn). A 10/21/25 Health Status Note stated the resident was agitated after dinner and repeatedly went in and out of resident rooms. Staff carried out 1:1 supervision with the resident to prevent further incidents. The administration of prn medication was ineffective. A 10/27/25