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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER: Newton Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 South Eighth Avenue East, 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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48886

Based on record review, resident interviews, staff interviews, and policy review, the facility failed to assure residents were treated with respect and dignity for 2 of 2 residents reviewed (Resident #13 and #40). The facility reported a census of 49 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #13 scored 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The resident required substantial/maximum assistance with toileting hygiene and toilet transfer. The resident's diagnoses included a stroke and Hemiplegia or Hemiparesis.

The Care Plan for Resident #13, with a revision date of 9/27/24, included a focus area for Activities of Daily Living (ADL), documented the resident had a self-care deficit as evidenced by required assistance with ADLs, impaired balance during transitions, required assistance and walking, incontinence, and left sided neglect. The intervention area instructed staff to provide 1 person assist with toileting, resident was incontinent of bowel and bladder. Provide peri care with every incontinent episode and as necessary.

During an interview 9/23/24 at 4:17 PM, Resident #13 stated about a month ago, he was constipated and a Certified Nursing Assistant (CNA) came in and gave him a bed pan. The CNA put the bed pan under him, he stated it was so far under him he could not move it himself. The resident stated the CNA left the room and left the bed pan under him for 3-4 hours. The resident stated it was so uncomfortable and hurt. The resident did not know the name of the CNA. The resident advised he talked to the Administrator about this and he was advised it would be taken care of. The resident stated it was incredibly uncomfortable to have the bed pan under him for 3-4 hours. The resident stated this incident took place in the night, not sure exactly what time, but knew he was left with the bed pan under him for hours.

(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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 9/30/24 at 2:30 PM, Staff C, Registered Nurse (RN), stated Resident #13 did talk to her about how he laid on a bed pan for a very long time, he said a CNA left a bed pan under him and did not return. Resident #13 told her about this the following morning, it happened in the night. Immediately after the resident telling her about this, Staff C called the Director of Nursing (DON) and the Administrator as it was on a weekend, she believed about a month ago. Staff C advised sitting with the resident that morning for awhile because he was upset. The resident also told her he did not like the way two CNA's talked in a foreign language while providing care to him as he did not know what they were saying. The resident reported to her feeling upset about the bed pan, and being left for a long time with the bed pan under him, and feeling upset about the two CNA's talking in a language he did not understand while in his room. During an interview 10/1/24 at 9:00 AM, the Administrator stated she recalled an incident reported to her on a Sunday morning about a month ago regarding Resident #13. Staff C called her and told her that the resident reported to her two CNA's were rough with him. The Administrator does not recall getting any other information from Staff C, she does not recall being told about the resident waiting for hours or a long time with a bed pan under him. The Administrator stated she talked to the resident on the phone that morning to get more information. He told her he felt two CNA's rushed his cares that night and were talking in their own language, he could not understand what they were saying and they were laughing. He did not say they were abusive to him, just that they rushed through cares and laughed, he thought they were laughing at him. The Administrator told the resident the CNA's would not provide care to him again, he was happy with this resolution. The Administrator said she educated the two CNA's about customer service and not talking in their own language around the residents who could not understand them. These two CNA's only work PRN (as needed) hours. The Administrator stated she does not recall anything about the bed pan, but does remember the resident saying he had to wait a long time for a call light response. The Administrator completed an incident report. The Administrator stated an expectation residents are treated with dignity and respect. 40905 2. The MDS for Resident #40, dated 8/15/24, included diagnosis of Non-Alzheimer's Disease and required assistance of 1 staff for transfers and toileting. A BIMS score of 11, indicated moderate cognitive impairment for decision-making. Interview on 9/23/24 at 4:20 PM, Resident #40 stated the staff do not always answer the call light timely, then she pees in her pants, and it is embarrassing and makes her feel ashamed as she should not have to pee in her pants. The facility policy Quality of Life-Dignity revised August 2009 instructed that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Interview on 10/02/24 at 11:03 AM, the Director of Nursing stated an expectation to answer call lights timely to assist residents with toileting.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 40905 Based on record review, staff interview, and policy review the facility failed to have an Iowa Physician Orders for Scope of Treatment (IPOST) (medical order form with code status that records residents' treatment wishes in the event of a medical emergency) for 1 of 24 residents reviewed (Resident #49). The facility reported a census of 49 residents. Findings include: The Minimum Data Set for Resident #49, dated 9/12/24, included diagnoses of osteoporosis bone disease that causes bones to become brittle) and age-related physical disability and included a Brief Interview for Mental Status score of 11, indicating mild cognitive impairment for decision-making. Resident #49's Admission Narrative Bundle/Baseline Care Plan, dated and signed by the resident on 9/6/24, documented a Code Status of Do Not Resuscitate (DNR). Review of facility IPOST book and Resident #49's electronic record lacked an IPOST form for Resident #4 and lacked a physician's order for a code status. Interview on 9/25/24 at 10:55 AM, Staff G, Registered Nurse stated in the event of the need to check a resident's code status she would check the IPOST book first, and if not there, would check the physician's orders and if no order for code status she would treat the resident like a full code and perform cardiopulmonary resuscitation on the resident. Staff G confirmed Resident #49 did not have an IPOST form in the IPOST book and did not have a physician's order for code status. Facility policy of Advanced Directives, revised December 2016, instructed advance directives will be respected in accordance with state law and facility policy. Interview on 9/25/24 at 11:10 AM, the Director of Nursing stated an expectation to have an IPOST completed for all residents and in the IPOST book.

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48886

Based on clinical record review, resident interview, staff interview, and policy review, the facility failed to follow professional standards of nursing care to ensure treatments and dressings were being completed and documented for 1 of 3 residents reviewed for wound care (Resident #1). The facility reported a census of 49 residents.

Findings include:

The Annual Minimum Data Set (MDS), dated [DATE], documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS further documented diagnoses to include other orthopedic conditions and malnutrition. The MDS revealed Resident #1 was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries. The resident had a stage 3 pressure ulcer: full thickness tissue loss. The MDS further documented the resident had moisture associated skin damage (MASD) to her feet.

The Care Plan for Resident #1, with a revision date of 9/20/24, documented under the focus area the resident had the potential for and actual impairment to skin integrity with an unstageable wound to the left ischial tuberosity (sitting bones), unstageable to coccyx (small triangular bone at the base of the spinal column), vascular ulcer to right inner ankle, left front lower extremity, and to the left foot. The Care Plan instructed staff to follow treatment order scheduled/prescribed by the wound care ARNP (Advanced Registered Nurse Practitioner).

During an interview 9/24/24 at 11:08 AM, Resident #1 stated she has wounds on both of her feet. She stated

staff do not always do the same treatment, one day it is done one way and the other day it is done another way. The resident stated staff do not always put the white stuff on.

Clinical record review of Resident #1's Treatment Administration Record between the months of June of 2024 through September of 2024 revealed treatments not recorded or documented as completed. For the month of June the following treatments/orders were not completed: CHLORHEXIDINE SOL 4%, Apply to entire body topically one time a day for cleansing for 30 Days, start date 5/11/2024 - not completed on June 6th, 2024. Order for left hip: cleanse with wound cleanser, apply skin prep to the peri wound and allow to dry completely, and cover with large [NAME] silicone super absorbent dressing; change daily and PRN (as needed) one time a day for wound care, with a start date 5/27/2024, and an end date 6/23/2024; this was not completed on June 6th, 2024. Order for MINERIN cream, apply to BLE (bilateral lower extremities) topically two times a day for dry skin, with a start date 5/16/2024; this was not completed on the night shift of June 1, 2024 and the day shift of June 6, 2024.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For the month of July 2024, the following treatments/orders were not completed: DAKINS solution 0.125%, apply to left ischial tuberosity topically one time a day for wound care, clean with quarter strength DAKINS, apply collagen into wound bed, loosely pack with Iodoform, cover with Silicone dressings, start date of 6/14/2024; this was not completed July 6th, July 7th, or July 20th. Order for DAKINS solution 0.25%, apply to Left Ischial tuberosity topically one time a day for wound care, with a start date of 7/26/24; not completed on July 28th. Order for Left foot: start to clean with betadine, apply a nickel thick layer of Santyl into wound bed, cover with an ABD pad and secure with gauze roll. Change daily and PRN, with a start date 7/01/2024; not completed July 6th, July 20th, or July 28th. Order for Left lower leg: Clean with betadine, apply a nickel thick layer of Santyl into wound bed, cover with an ABD pad and secure with gauze roll. Change daily and PRN, one time a day for wound care, with a start date of 7/1/24; not completed July 6th, July 7th, July 20th, and July 28th. Order for constant compression to legs at all times, ace wraps. Check circulation every shift two times a day for leg integrity, with a start date of 7/18/2024; not completed July 19th and July 20th. Order for MINERIN cream, apply to BLE (bilateral lower extremities(legs))topically two times a day for dry skin, with a start date 5/16/2024; not completed July 6th, July 19th, July 20th, and July 23rd. Order for NYAMYC powder 100000, apply to right neck topically two times a day for MASD, with a start date of 6/7/24; not completed July 6th, July 19th, and July 20th. For the months of August 2024 and September 2024, the following treatments/orders were not completed: DAKINS solution 0.125%, apply to left ischial tuberosity topically one time a day for wound care, clean with quarter strength DAKINS, apply collagen into wound bed, loosely pack with Iodoform, cover with Silicone dressing and change daily, start date of 8/18/2024; this was not completed August 18th, August 20th, August 21st, September 3rd, September 26th, and September 28th. Order for left foot: start to clean with betadine, apply a nickel thick layer of Santyl into wound bed, cover with an ABD pad and secure with gauze roll. Change daily and PRN, start date of 7/01/2024; not completed August 20th, August 21st, and September 3rd. Order for left ischial tuberosity: continue treatment to cleanse with quarter strength Dakin's solution 0. 25%, apply collagen powder into wound bed and loosely pack the tunneling with Iodoform gauze strip and cover with a silicone super absorbent dressing change daily and PRN one time a day for treatment, with a start date of 8/16/2024; not completed August 20th, August 21st, and September 3rd. Order for Left lower leg: Clean with betadine, apply a nickel thick layer of Santyl into wound bed, cover with an ABD pad and secure with gauze roll. Change daily and PRN one time a day for wound care with a start date of 7/01/2024; not completed August 20th and August 21st. Order for NYAMYC powder 100000, apply to right neck topically two times a day for MASD, with a start date of 6/7/24; not completed September 3rd, September 7th, September 14th, September 26th, and September 28th. Order for Skin prep to scab to right second toe BID (twice daily) until healed, with a start date of 8/22/2024; not completed September 3rd, September 7th, and September 28th. During an interview 9/30/24 at 1:00 PM, the Director of Nursing (DON) stated their electronic health care system was down on the 9th and 10th of September and they used paper charting for those days, and on occasion from the 11th to the 13th of September. The other dates of missing documentation in the TAR for Resident #1, the DON stated could have been her not documenting when she completed treatment as she does not take her cart or computer into the room and will forgot to do the documentation in the TAR. The DON will look into the dates and find hard copy or some notation the treatment was completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 10/01/24 at 11:00 AM, the DON advised she reviewed the TAR for August and September for Resident #1 and inquired from nursing staff working on the days that were missing documentation of the treatment being completed if they recalled doing the treatment. Some of the nursing staff did recall doing the treatment, however acknowledged they did not document the treatment in the TAR. The DON stated on some of these dates, she did the treatment for Resident #1 and forgot to document in the TAR the treatment was completed. The DON stated there were some days in June, July, August, and September that there is no recall of completing the treatment and it is likely the treatment was not completed. The DON stated an expectation staff chart immediately after completing the treatment in the TAR and an expectation treatments and orders are followed as prescribed. During an interview 10/01/24 at 2:30 PM, the Administrator stated an expectation staff chart and document in the TAR immediately after treatment is completed. The Administrator stated an expectation treatment be completed as ordered. Review of the facility policy: Charting and Documentation, with a revision date of July 2017, documented all services provided to the resident shall be documented in the resident's medical record. Review of the facility policy Provision of Physician Ordered Services, undated, documented care and services are provided according to accepted standards of clinical practice to provide a reliable process for the proper and consistent provision of physician ordered services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40905 Based on observation, resident and staff interview, record review, and policy review the facility failed to assist residents with shaving for 2 of 10 residents reviewed (Resident #27 and #40). The facility reported a census of 49 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #27, dated 9/12/24, included diagnoses of Parkinson's (disease affecting the nervous system) and muscle weakness. A Brief Interview for Mental Status (BIMS) score of 15, indicated no cognitive impairment for decision-making. Observation and interview on 9/24/24 at 11:21 AM, Resident #27 with approximate 1/8-inch facial hair covering cheeks, upper lip, and chin. Resident #27 stated he needed to be shaved but only gets shaved on shower days, Tuesday and Friday. Resident stated he would like to be shaved more often, at least 3 times a week consistently. Resident stated the facility was frequently out of razors. Interview on 9/25/24 at 3:09 PM, Resident #27 stated he did not have shower yesterday as scheduled, have not been shaved, and staff do not offer to shave when assisting with morning cares. Resident #27's shower sheet dated 9/20/24 with documentation of don't have razors so I couldn't shave him. 2. The MDS for Resident #40, dated 8/15/24, included diagnosis of Non-Alzheimer's Disease. A BIMS score of 11, indicated moderate cognitive impairment for decision-making. Observation and interview on 9/23/24 at 4:13 PM, Resident #40 had approximate 1/8-inch gray/black/white facial hair on full chin. Resident #40 stated she does not like the facial hair, would like to be shaved more frequently as only shaved on shower days. Observations and interviews on 9/24/24 at 10:05 AM and 9/25/24 at 10:47 AM, Resident #40 remained with facial hair and resident stated she had not been shaved. Facility policy for shaving the resident revised February 2018 documented the purpose of the procedure is to promote cleanliness and to provide skin care. Interview on 9/26/24 at 9:13 AM, the Director of Nursing stated an expectation to shave residents on shower days and more frequently if the residents ask.

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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** 48886 Based on clinical record review, resident interview, staff interviews, and policy review, the facility failed to accurately assess and provide intervention to 1 of 1 residents when a resident reported shoulder pain (Resident #13). The facility reported a census of 49 residents. Finding include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #13 scored 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The resident required substantial/maximum assistance with toileting hygiene and toilet transfer. The resident's diagnoses included a stroke and Hemiplegia or Hemiparesis. The Care Plan for Resident #13, with a revision date of 9/27/24, included a focus area for Activities of Daily Living (ADL), documented the resident had a self-care deficit as evidenced by requiring assistance with ADLs, impaired balance during transitions requiring assistance and walking, incontinence, and left sided neglect. The intervention section instructed staff to provide 1 person assist with toileting, resident is incontinent of bowel and bladder. Provide peri care with every incontinent episode and as necessary. The Care Plan further included a focus area for pain, documented the resident was at risk for pain/discomfort and increased risk for injury from decreased function related to diagnosis of stroke with left sided weakness and hernias. During an interview 9/23/24 at 4:14 PM, Resident #13 stated about two to three weeks ago, a Certified Nursing Assistant (CNA), Staff D, was moving fast during cares while the resident was in bed. The resident stated Staff D slid him to the side to change him while he was in bed and his shoulder hit the wall. The resident stated his shoulder popped and it hurt. Staff D said oh and looked at the resident after this happened. Resident #13 stated he told a nursing staff, not sure of name, and she did not do anything, but did give him Tylenol. The resident stated his shoulder hurt like hell. The resident stated they never had him go to the doctor, and no one did an assessment on his shoulder. The resident stated his shoulder does not hurt anymore, but it hurt for awhile. The resident stated he had a stroke and was at this facility for skilled care, he had urine in his bed that night and he needed help with ADL's. The resident stated it was his left shoulder that hit the wall and popped that night, he was not sure of the time of day, he thought it was at night. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 9/30/24 at 4:06 PM, Staff D stated Resident #13 told a staff member, Staff E, Certified Medical Assistant (CMA), that he slammed the resident into the wall. Staff D stated he did not do that. Staff E advised Staff D of the resident telling her this after she came out of the resident's room later that night. Staff D advised he works the 2-10 PM shift. Staff E told Staff D she did not believe he would do anything like this and said she did not think Staff D slammed the resident into the wall. Staff D thought the resident to be a two person assist, he is not sure. Staff D stated that night he went into the resident's room by himself to change the resident's brief. Staff D stated he did change his brief, during that process, he slid the resident toward him and grabbed his shoulder, his sore shoulder (the left one), and the resident told Staff D it hurt when he did that. The resident told Staff D he popped his shoulder out, but Staff D did not believe he did. The resident then told Staff E, the CMA working that night, that he slammed the resident's shoulder into the wall. Staff D stated he did not slam him into the wall. Staff E came out of the resident's room and told Staff D what the resident said, that he slammed him into the wall and popped his shoulder out. Staff E gave the resident Tylenol. Staff D stated the resident was lying, Staff D said he did not slam him into the wall. Staff D stated he did move the resident by his left shoulder and he knew the resident had pain in his left shoulder. Staff D stated he has not gone in to the resident's room alone again to provide care to the resident, by his own choice. Staff D stated he did not talk to management about this incident. Staff D stated he and Staff E did not talk to the charge nurse that night, or since then about this incident. Staff D believed the incident was a couple of weeks ago. During an interview 10/01/24 at 9:30 AM, the Administrator stated she was not aware of any reported incidents with Resident #13, other than what we talked about already with this resident. The Administrator stated the resident has pain and it does hurt him to move. During an interview 10/01/24 at 9:51 AM, Staff E stated she recalled Resident #13 telling her Staff D pushed his shoulder a little too hard, that he rolled him too hard. Staff E stated she did not recall Resident #13 saying Staff D popped his shoulder out. Staff E stated she came out of the resident's room and told Staff D they should tell the charge nurse what the resident said. Staff E did not remember when this was, she did not remember who the charge nurse was or what the charge nurse said, she thought she and Staff D talked to the charge nurse together. She thought it was a few weeks ago. Staff E stated Staff D told her he did not think he rolled the resident too hard. When asked if the resident said he was in pain, Staff E stated she did not remember. When asked if she gave the resident Tylenol for pain, Staff E stated she did not remember. When asked who are some of the charge nurses she works with, Staff E stated she did not know any of their names. Review of electronic health record did not reveal an assessment on Resident #13's shoulder, or follow up regarding the incident. During an interview 10/01/24 at 1:39 PM, the Administrator stated she had no knowledge of this incident, it was not reported to her or to the Director of Nursing (DON), this is the first she is hearing about this. The Administrator stated an expectation the CMA report this to the charge nurse and to the DON and/or Administrator and that an assessment and evaluation be completed on the resident's shoulder. If a resident reported being slammed into a wall and having pain in their shoulder and feeling their shoulder had popped out, an assessment and evaluation needed to completed to determine if the resident had an injury and if the resident required medical attention, and to adequately address and manage the pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Pain Management and Assessment policy, with a revision date of March 2015, documented pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is a multidisciplinary care process that includes assessing the potential for pain.

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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. 48886 Based on observation, record review, staff interview, and policy review, the facility failed to ensure safe transport of residents in a wheelchair for 1 of 24 residents reviewed (Resident #1). The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) for Resident #1, dated 8/22/24, documented the resident had diagnoses to include other orthopedic conditions, unspecified lack of coordination, difficulty in walking, and other abnormalities of gait and mobility. The MDS further documented the resident used a walker and a wheelchair for mobility devices. The MDS revealed the resident was independent with the ability to wheel at least 50 feet and make two turns once seated in the wheelchair. The Care Plan for Resident #1, with a revision date of 9/20/24, documented the resident does propel herself to and from activities with no issue. The Care Plan instructed staff to ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. During an observation 9/24/24, at 9:40 AM, Staff A, Certified Nursing Assistant (CNA), pushed Resident #1 while she was seated in her wheelchair, her feet were not on foot pedals, she had them lifted up off the ground, holding them off the ground while Staff A pushed her in the wheelchair. The resident did not have footwear on, she was barefoot and had a wrap around her calves that covered half of her foot, leaving her toes exposed. The resident was pushed from her room, down the 300 hallway and into the dining room without the use of foot pedals. During an interview 9/24/24 at 9:50 AM, Staff A advised normally will use foot pedals when pushing a resident in a wheelchair. Staff A stated he was told by management to not use foot pedals with Resident #1 a little while ago due to her having skin issues on her legs. Staff A felt he should still use foot pedals as it is a safety concern, however acknowledged he did not use foot pedals earlier with Resident #1. During an interview 9/25/24 at 11:15 AM, the Director the Nursing (DON) stated an expectation staff use foot pedals when pushing a resident in a wheelchair. The DON stated Resident #1 can propel herself in her wheelchair and does not typically require assistance in her wheelchair. The DON advised current management have not informed any staff not to use foot pedals with Resident #1. The DON stated a safety concern not using foot pedals when pushing a resident in a wheelchair. Review of the facility policy: Accidents and Supervision, with a copyright date of 2023, documented the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER: Newton Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 South Eighth Avenue East Newton, IA 50208	

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on resident and staff interviews, record review, and policy review the facility failed to respond to call lights in a timely manner and provide adequate weekend staffing to meet residents needs. The facility reported a census of 49 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #27, dated 9/12/24, included a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Interview on 9/24/24 at 11:27 AM, Resident #27 stated staffing on the weekends is really bad as have less staff and call lights are not usually answered timely on weekends. The MDS for Resident #52, dated 9/11/24, included a BIMS score of 14, indicating no cognitive impairment. Interview on 9/23/24 at 3:07 PM, Resident #52 stated less help on the weekend and takes longer than 15 minutes for their call light to be answered on the weekends. Interview on 9/24/24 at 10:22 AM, Staff F, Certified Nurse Aide (CNA) stated the facility has extra staff to assist during the week as management/office staff assist with answering call lights, pushing residents about facility, and also have a hospitality aide that assists with answering lights, filling water pitchers, and meals. Staff F stated on the weekend they work with at least 1 less CNA, not including if they have call-ins and if no replacement, and do not have the extra staff that assist during the week. Staff F stated she feels not able to meet the needs of the residents, not able to assist them timely, and residents are incontinent due to not assisting them quickly enough on the weekends due to the lower number of staff on the weekends. 48886 2. During an interview 9/24/24 at 11:17 AM, Resident #1 advised feeling the facility did not have enough staff to meet resident's needs. The resident stated about two days ago, on the weekend, resident waited an hour and 45 minutes after pulling call light. The resident pushed the call light as they wanted to get up in the morning, and waited that long for someone to come. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. During an interview 9/24/24 at 1:36 PM, Resident #26 stated the facility had been short staffed on the weekends. The resident stated staff would call in and not show up for work. The facility would try to find other people to fill in. There have been a few times the resident waited a half hour for a call light response. The resident stated she pushed her call light due to pain with arthritis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the MDS assessment dated [DATE] Resident #26 scored 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the facility grievance binder revealed a resident grievance form filed by Resident #26, reported she waited for call light for 30-45 minutes before wheeling up to the nurses station without oxygen at 3:00 AM. This was reported on 9/14/24, a Sunday. The investigation/outcome section of the grievance form documented follow up with nurse, aides were in rooms on rounds and nurse was with another resident. Will educate about staffing cares, call light audit. Call light audit shows audits completed 5 times, during day time hours and during the week, not on the weekend or in the middle of the night, completed 9/17/24 to 9/24/24. During an interview 10/01/24 at 2:26 PM, the Administrator was advised of the low weekend staffing trigger for the 3rd quarter in 2024, April 1st to June 30th. The Administrator stated their staffing numbers vary according to the census. The Administrator stated the administration team has come in often on the weekends and this would be on the schedule. The Administrator gave the necessary staffing numbers for the facility at full census, 70 residents, however did not give the necessary staffing numbers for the census being lower, stated they then use the 3.0 range to calculate staffing according to their census when they are not full. The Administrator stated they do not alter the number of staff working from the week to the weekend, the staffing stays the same. The Administrator stated they had a lot of call ins during the 3rd quarter and they were low in staffing due to weekend call ins and staff not showing up to work. They had attendance issues then. They have more staff hired now and rotate staff on weekends. The Administrator advised the facility has had some complaints from residents on call light response time, when they get complaints they do audits. During an interview 10/2/24 at 8:45 AM, the Administrator stated an expectation call lights be answered as quickly as possible and within 15 minutes. Review of facility policy Call Lights: Accessibility and Timely Response, implemented 12/1/23, documented the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40905 Based on observation, clinical record review, staff interview, and policy review, the facility failed to maintain infection control standards by not wearing personal protective equipment (PPE) of a gown and gloves while providing high contact care activity for a resident on enhanced barrier precautions (EBP) (an infection control intervention requiring staff to wear designated PPE to reduce transmission of organisms for designated residents) for 1 of 2 residents reviewed (Resident #50). The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) for Resident #50, dated 9/1/24, included a diagnosis of acquired absence of right leg above knee due to surgical amputation with a surgical wound and documented the resident had a Foley catheter. Observation on 9/24/24 at 3:17 PM, Resident #50 room door with a sign posted for EBP and PPE supplies outside door and resident sitting in a recliner with a Foley catheter (tube into penis to drain urine), wound vacuum (vac) (machine with tube attached to dressing on wound to pull drainage from wound) attached to right leg stump. Observation on 9/30/24 at 9:23 AM, Staff B, Registered Nurse (RN) was in Resident #50's room standing by the resident's bed without a gown or gloves on. Staff B proceeded to lift the resident's bed sheet with her right hand to look at the wound on the resident's leg, touched the wound vac tubing with her left hand, and without completing hand hygiene touched her own clothing by placing hands on her sides. Interview on 9/30/24 at 1:00 PM, Staff C, RN stated with any resident with EBP has sign on their door and EBP if has any type of tube, such as catheter, ostomy, or wounds. Staff C stated the protocol is to wear a gown, gloves, and mask anytime staff are going to provide direct care to the resident on EBP. Staff C stated she would wear PPE to look at a wound, when touching residents' bedding, or touching the wound vac and tubing. Facility policy for Enhanced Barrier Precautions revised 3/21/24 the facility should use EBP for residents that meet the following criteria, during high-contact resident care activities: EBP are indicated for residents with any of the following: wounds and/or indwelling medical devices (including urinary catheter). Examples of high-contact resident care activities requiring gown and glove use include: changing linens and device care or use. Interview on 10/01/24 at 3:00 PM, the Director of Nursing (DON) stated staff are to wear required PPE in the resident's room when providing positioning, transfers, or any contact where staff or staff clothing come in contact with the resident. The DON further stated the expectation to wear PPE when touching the resident's sheets, looking at a wound, or touching a wound vac/tubing.