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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaldaya Lifescapes	7511 University Avenue Cedar Falls, IA 50613

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility records, policy review, and staff interviews, the facility failed to prevent a resident from being physically restrained when a gait belt was placed around the resident's waist and a secured with a second gait belt to the recliner for 1 of 3 residents (Resident #1) reviewed. The facility reported a census of 104.Findings Include:Resident #1's Minimum Data Set assessment dated [DATE] documented an admission date of 12/28/25. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. The MDS listed potential indicators of psychosis (mental health symptom involving a disconnection) of hallucinations (Sensing, seeing, or hearing things that are not actually there). Resident #1 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for lying to sitting on the side of the bed, sitting to standing, chair/bed-to-chair transfer and walking. The MDS included active diagnoses of Alzheimer's disease, cerebrovascular accident (stroke caused by interrupted blood flow to the brain), and anxiety disorder. The Care Plan Report initiated 11/28/25 identified Resident #1 identified the following Focuses:Self-care deficit related to impaired cognition, decreased mobility and cerebral infarction (when blood flow to the brain is blocked).Likes to be busy. Please provide meaningful activities. Enjoys folding towels/matching socks.Likes to go to bed around 8:30-9:00 PM. If she gets up in the night provide towels to fold and then attempt to lay back down.Enjoys Christian music.Transfer/ambulation: assist of one with gait belt and walker. Walk around the unit twice daily. Provide positive reinforcement for increased activity.Disruptive behavior problems evidenced by expressing frustration, agitation, rummaging, and having hallucinations.Determine if behavior is stimulated by certain activities, noise levels, person involved or time of day.Specify: over stimulation, lonelinessDiscuss behavior with resident; watch for behavioral clues to understandDivert attention from stimulusGive assistance when needed in activities such as cueing, reminders and directionMonitor behavior to assist in determining causeTalk with resident in a calm mannerUse relaxation techniquesGive a baby dollExerciseMusicThe Care Plan Report lacked Resident #1 frequently attempts to rise unassisted. Resident #1's February 2026 Documentation Survey Report identified Staff A, Certified Nursing Assistant (CNA), documented on 2/24/26 at 11:16 PM no behaviors occurred for the overnight shift for behavior monitoring and interventions. The Incident Note dated 2/25/26 at 2:30 AM, indicated a staff member used a gait belt inappropriately by fastening it to another gait belt around Resident #1's waist while they sat in the recliner. With the incorrect use of the gait belt, Resident #1 could move her arms, legs, and torso forward but couldn't stand up on her own. The note described the situation as an unsafe and unauthorized use of a gait belt. The nurse assessed Resident #1 for any injuries, finding no redness or bruising noted. The Social Service Progress Note dated 2/25/26 at 4:39 PM documented the Social Worker met with Resident #1. She appeared happy, holding a baby doll. When asked if anyone has said or done anything to her to make her feel uncomfortable or unset, she stated no. When asked if staff treated her nicely, she stated yes. Resident #1 smiled and told the Social Worker about how well the baby behaved and never cried. The (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Notes lacked documentation for attempted interventions, medical necessity for placement of a physical restraint, physician notification, family education and/or consent. On 4/21/26 at 11:35 AM, observed Resident #1 sitting in a rocking recliner in the common area, with her walker positioned in front of her within reach. She wore glasses and tennis shoes. Resident #1 didn't appear agitated, anxious, or attempt to rise unassisted. On 4/21/26 at 1:25 PM, observed Resident #1 sitting in a rocking recliner in the common area. She sat with her right leg crossed over her left at the knees, with her left foot on the floor. Resident #1 sat quietly awake with her front wheeled walker within reach on her left. She had a gait belt looped on the front of the walker. Resident #1 didn't appear agitated, anxious, or attempt to rise unassisted. On 4/21/26 at 3:01 PM Staff B, Certified Nurse Aide (CNA), confirmed her knowledge of resident rights, Dependent Adult Abuse (DAA), and the proper use of a gait belt for a resident transfer and ambulation. Staff B stated she reports allegations of abuse immediately to the nurse, Assistant Director of Nursing (ADON) or the Director of Nursing (DON). Staff B described Resident #1 as a very sweet resident requiring 1-assist for transfers with a gait belt and walker. Staff B verbalized Resident #1 at times rises independently and can get wobbly. Staff B reported she found Resident #1 on an unspecified date at approximately 2:40 AM, with one gait belt loosely around Resident #1's waist and a second belt wrapped tightly around the side of recliner preventing Resident #1 from rising. Staff B required assistance from Staff C, Registered Nurse (RN), to remove the secured gait belt. Staff B stated she didn't witness any staff members apply the gait belts to Resident #1 or the recliner. Staff B didn't know how long Resident #1 sat with the gait belts restraining her from rising. Staff B toileted Resident #1, walked her around the unit, and sat next to her until her shift ended at 3:00 AM. Staff B reported Resident #1 didn't appear agitated or scared. She didn't notice redness or injuries when she assisted her to the toilet. On 4/21/26 at 3:2, Staff A, CNA, stated he showed dignity and respect by explaining things, allowing privacy, asking what made the residents feel comfortable, and let them have a voice. He received training on resident rights and DAA. He verbalized he would report DAA allegations to a nurse. Staff A acknowledged he received training on the proper use of a gait belt for resident transfer and confirmed staff shouldn't use a gait belt to prevent a resident from rising. Staff A reported Resident #1 required assistance from one staff. She needed watched 24/7 because she often attempted to rise on her own. He verbalized when Resident #1 tried to rise unassisted, he tried to keep her close, visit with her, or give her food to keep her occupied. Staff A admitted he used a gait belt improperly on an unspecified date. Staff A reported Resident #1 experienced days without sleep and hallucinated. She tried to get up and becoming combative. Staff A placed a gait belt around her waist, buckled it in the back, then used a second gait belt as an extender, looping it around the side of the recliner to prevent her from falling. Staff A admitted the action prevented Resident #1 from rising. Staff A thought this acted as a safety measure since he didn't want her to fall, but later recognized his judgment was wrong because he didn't follow the care guide. He reported he never did that prior to the incident. On 4/21/26 at 3:50 PM, Staff B demonstrated how she found the 2 gait belts. She placed one buckled gait belt in the seat of the recliner. She next looped a second gait belt through the first gait belt. The second gait belt was buckled and placed over the right side (facing the recliner) of the backrest. The back rest of the recliner has sections on both sides of the back rest that extend out even with the arms of the recliner. The recliner had the gait belt looped over the top of that section and tucked under the bottom where it met the arm rest. On 4/21/26 at 3:21 PM Staff C confirmed Resident #1 often attempted to rise by herself and fell in the past. Staff C reported the staff used a gait belt to ambulate residents. Staff C received report that a staff improperly used a gait belt on Resident #1. Staff C reported they used 2 gait belts with one of the belts tucked into the recliner. Staff C acknowledged she assessed Resident #1 and found no injuries. Staff C reported she informed Staff A he couldn't use gait belts that way. Staff C acknowledged she educated Staff A that doing so is a restraint. On 4/22/26 at 3:25 PM, the DON explained they expected the staff to assess the resident for reasons of restlessness (checking for pan, toileting needs, hunger). The DON reported staff should ambulate, reposition, use all (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-pharmacological interventions, and consult with team members including the nurse. The DON reported they need to use gait belts to safely ambulate or steady a resident who needed assistance. The DON acknowledged they must remove a gait belt once they finish ambulating the resident. The DON voiced Resident #1 wouldn't be able to rise if she had a gait belt around her waist with a second gait belt looped around the side of the recliner. The DON reported she didn't know of any emergent situation requiring a physical restraint to permit medically necessary treatment. The DON revealed the staff member should've assessed the resident's needs (toilet, ambulate) and use non-pharmacological interventions before talking with team members and the nurse. The DON confirmed the facility expected the staff members to not physically restrain residents. Review of the facility video footage with a date time stamp of 2/25/26 at 2:45 AM, revealed as Resident #1 sat in a recliner facing the fireplace, Staff A approached her and leaned her forward, securing the second gait belt to the recliner. The video showed Resident #1 able to move in the recliner and grab things. Review of Staff A's Employee File documented a hire date of 3/14/23 for a CNA position. The file included the following:The Job Description/Evaluation form Certified Nurse Aide position signed 3/14/23 by Staff A describe the position as to provide assigned residents with routine daily nursing care, following established nursing procedures and supervisor directives.The CNA Orientation Checklist signed by Staff A on 3/22/23 indicated they received training for gait belts.Staff A received Dependent Adult Abuse Mandatory Reporter Recertification training on 2/17/24.The CNA Orientation Checklist signed by Staff A on 6/9/24 indicated they received training for gait belts.Review of the facility's Safety Fair 2025 signed by Staff A on 12/12/25, included gait belt use and resident rights. Review of the Resident Rights facility policy revised 2/18/26 instructed the facility to ensure all direct care and indirect care staff member received education on the rights of residents and the responsibility of the facility. The resident has the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility. The resident has a right to be treated with respect and dignity.The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.The resident has a right to a safe, clean, comfortable and homelike environment including but not limited to receiving treatment and supports for daily living safely. Review of the Gait Belt/Transfer Belt facility policy dated 2/17/94 directed the following:All CNAs are assigned a transfer belt at the beginning of employment.The CNA must keep the transfer belt with him/her at all times while working on the unit.The CNA must use the transfer belt when assisting any resident.The CNA will check their care guide and any resident who is stand by assist or physical assist of 1 or 2 must use the belt.The Gait Belt/Transfer Belt policy lacked directions for transfer belt not to be used as a physical restraint. Review of the Restraint Free Environment facility policy reviewed 12/29/25, instructed the following:Each resident shall attain and maintain his/her highest practicable we-being in an environment prohibits the use of physical or chemical restraints for discipline or conveniency and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints.Physical restraint refers to any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body. Physical restraints may include, but are not limited to:Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents them from rising.Placing a resident in a chair that prevents the resident from rising independently.