STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165525	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The New Homestead Care Center	2306 State Street Guthrie Center, IA 50115

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical record review, facility document review, personnel file review, resident interview, family interview, staff interviews, and facility policy review, the facility failed to protect 1 of 3 residents (Resident #1) reviewed from abuse. The facility reported a census of 46 residents. Findings include: Clinical Record Review of Resident #1 Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS reflected diagnosis of stroke, hemiplegia or hemiparesis following cerebrovascular affecting the left side, urge incontinence, pain in left hip, pain in unspecified knee, anxiety disorder and depression. The MDS further documented Resident #1 required total dependence on staff for performing most activities of daily living. The Care Plan documented Resident #1 had behaviors related to depression, anxiety, vascular dementia, personal history of other mental and behavioral disorders and directed staff to implement intervention of maintaining a calm environment and approach to the resident. It further directed staff to communicate with the resident using the resident's preferred name, staff to identify themselves at each interaction, face the resident when speaking and to make eye contact, observe the resident for signs and symptoms of depression, and to encourage residents to verbalize feelings, concerns and fears. The Care Plan also documented Resident #1 needed 24-hour care related to left side paralysis from major stroke and inability to care for herself and required wheelchair mode of transportation to and from activities including toileting assistance. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER The New Homestead Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2306 State Street Guthrie Center, IA 50115	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility reported incident dated 11/05/24 documented the following: on 10/31/24 Staff A, CNA was recorded on the camera in Resident #1 's room while providing cares and during the cares. The video shows the nurse aide rushing and not demonstrating compassion towards the resident that is sitting in her recliner. The Nurse Aide brings the stand lift to the front of the resident to prepare for the transfer. She very quickly removes the call light which gets looped in resident hair. She abruptly removes the head pillow from behind the resident's head and tosses it onto the bed that is across the room. She then proceeds to move the lift closer to the resident to place the resident's feet onto the platform of the lift. She takes her own foot to push down on the resident's lower leg/upper ankle area to position the foot for placement onto the lift platform. She proceeds to put the harness strap under the arms and hook it up to the lift as she should. The entire time she is not talking to the resident and appears to be in a rush to get the transfer completed. The resident asks to use the restroom, and the Nurse Aide responds in the video that it has only been 40 minutes since she used the restroom, and she can go to her wheelchair. The personnel file for Staff A included a certificate dated 8/19/23 certifying she completed the course for Dependent Adult Abuse. The Disciplinary Report Form for Staff A dated 11/1/24 documented video surveillance revealed the staff was not speaking to the resident during cares, staff positioned the resident's foot on the platform of the mechanical lift using force from her own foot, throwing residents belongings, and refused to take the resident to the bathroom when the resident requested to go. The form documented the staff suspended pending investigation. The Change in Hours Form documented Staff A was terminated from the facility on 11/5/24. In an interview on 2/19/25 at 12:25 pm Staff B, CNA, revealed she was in the vicinity of the interaction between Resident #1 and Staff A, CNA, but did not visually observe the whole interaction, only when Staff A, CNA was punched in the head and the stomach by Resident #1. She just knew she had to take Resident #1 out of the room after Staff A, CNA left the room. In an interview on 2/19/25 at 2:04 pm Staff C, Licensed Practical Nurse (LPN) stated she received a report from Staff A, CNA about Resident #1 hitting her. Staff C, LPN stated she did document the incident in the Progress Notes and reported it to the Director of Nursing (DON) and assessed the resident for injuries. Staff C, LPN further stated she did not ask Resident #1 questions to assess for safety and well-being of the resident after the interaction with Staff A, CNA. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER: The New Homestead Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2306 State Street, Guthrie Center, IA 50115	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Power of Attorney (POA) for Resident #1 on 2/19/25 at 2:14 pm she revealed receiving a call from the facility on 10/31/24 notifying her of the incident about her mother hitting a staff member. She reviewed the camera footage immediately prior to the incident and stated she was horrified about what happened to her mother. Resident #1 POA stated she filed the report with the State Agency and reported the following: To my horror, the video showed the staff member being extremely rude, condescending, and rough with my mother. The staff used her own foot to push my mother's down while putting her in an ez stand. The entire two minute video shows her being rough and pushing my mother around, denying her a shawl when she is cold and jerking her body aggressively and inappropriately. This staff member knows my mother has pain throughout her body and is paralyzed on her left side, yet the staff member is particularly rough to her left side. The video captures audio of the staff member stating that my mom had just gone to the bathroom [ROOM NUMBER] minutes prior and would go straight to the wheelchair My mother had been having a very hard time sleeping the days prior and expressed her fear. POA further stated she did not want Staff A, CNA to treat her mother this way or any other resident for that matter. In an interview with Resident #1 on 2/19/25 at 3:00 pm, she stated her left side was useless and numb, her arms were overworked and rotator cuffs were gone. It was painful for her to raise both of her arms to get into the mechanical stand for transfers. She verbalized ouch everyday to Staff A, Certified Nurse Assistant (CNA) but she didn't believe her. On 10/31/24 Resident #1 stated she needed assistance with transferring and Staff A, CNA was rough with her and hurt her left foot that was paralyzed and it caused her more pain and also denied taking her to the bathroom. Resident #1 stated she hit Staff A, CNA because she had to fight for herself, she couldn't take it anymore. She had a hard time sleeping for weeks at that point because she felt like something bad was going to happen to her. Resident #1 further stated Staff A, CNA was getting rougher and rougher everyday and did something everyday to hurt my arm or leg and threatened to give her a cold shower and it made me panic. Resident #1 revealed Staff A, CNA brushed out her hair when it was tangled up and she was very rough and she told her you have long hair, you should know how it feels but Staff A, CNA told her you better cut it off if you can't take it. She also revealed Staff A, CNA was losing patience with everything and made it clear she was tired of working here, didn't like repetitive work and had a very sour attitude towards her. During an interview on 2/20/25 at 3:00 pm, Staff A, CNA, stated she went in on 10/31/24 around 9:30 am to get Resident #1 up for a vaccine clinic, she hooked her up to EZ stand (mechanical lift) to put her in the wheelchair and while she was bent down to put the residents' left foot on the pedal, Resident #1 hit her in the head, then as she was standing up, she got hit in the stomach. She then left the room. Staff A, CNA stated she didn't see it coming from the resident, she never got hit, this was the first time. She made a report to the charge nurse, and later around 1:45 pm, the charge nurse told her she had to go home. She hasn't returned to work since then. The Progress Notes for Resident #1 revealed the following: On 10/31/24 at 10:20 AM CNA reported to this nurse that when getting resident up from her recliner to the wheelchair, CNA bent down to put pedal on wheelchair, resident punched CNA upside the head. Two CNA's present during cares for resident. When CNA stood up, resident then punched CNA in the stomach. This nurse educated resident on appropriate behavior, not appropriate to hit staff. Resident then smiled then stated, I'm going to shoot her next. She's gonna put a knife in my head. Again, this nurse educated resident on verbal aggression towards staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER: The New Homestead Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2306 State Street Guthrie Center, IA 50115	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 2:30 PM full skin assessment performed head to toe with no bruising, no abrasions, no open areas, and no bumps noted. On 11/2/24 at 3:36 PM 48 hour follow up with no further behaviors noted. Resident has been pleasant towards staff and other residents. Review of the clinical record for Resident #1 revealed a police report was filed and the following outcome noted: no criminality but recommended more compassion during Activities of Daily Living (ADL's). During an interview with the Administrator on 2/20/25 at 12:30 pm he stated the residents should not be mistreated and his expectations were for residents to be treated with dignity and respect. The undated facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy undated, documented Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. If further outlined the following: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 6. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Mental abuse includes abuse that is facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. This would include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident's face, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position. 7. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. 9. Mistreatment means inappropriate treatment or exploitation of a resident. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER The New Homestead Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2306 State Street Guthrie Center, IA 50115	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or mental illness.