STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165427	A. BUILDING _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWTON HEALTH CARE CENTER	**200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: 5-6-2023 ✓ The following deficiencies resulted from investigation of complaints #107255-C, #111232-C, #111331-C, & #111478-C, conducted April 3, 2023 to April 6th, 2023. JFS Complaints #107255-C, #111232-C, #111331-C, and #111478-C were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	This plan of correction is submitted as required under State and Federal law, the submission of this Plan of Corrective does not constitute an admission on the part of Providence Living Center as to the accuracy of the surveyor's findings or the conclusions drawn there from. The Plan of Correction does not constitute an admission on the part of the Facility that the findings are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiencies cited are correctly applied. Any changes to Facility policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in and proceeding in the basis. The Facility submits this plan of corrective action with the intention that it be inadmissible by any third party in any civil or criminal action against the Facility or any employee, agent, officer, director, attorney or shareholder of the Facility. Statements of Deficiencies will be, taken to the facility's Quality Assurance/Assessment Committee.	

F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561	1. R1 is deseased. 2. Current residents have the potential to be affected by the alleged deficient practice. Current residents and/or responsible parties will have a copy of their rights and a copy of their rights under F561. 3. Current staff will be re-educated on resident rights to have their meds given at a time of their choosing 4/26/23 and on-going. 4. Administrator/designee will review medication time change requests from the facility for the next 2 months for adherence to policy. Administrator/designee will monitor current residents with specific medication time requests by reviewing their medication administration record Findings will be taken to QAPI for review. 5. Date of Compliance 5/6/23.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Matthew Memmer | Administrator | 4/27/23

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.

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F 561		F 561		

Continued From page 1

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interview, the facility failed to ensure a resident was able to carry out the right to make choices about aspects significant to the resident for 1 of 4 residents reviewed for resident rights (Resident #1). The facility reported a census of 56 residents.

Findings include:

The Minimum Data Set (MDS) assessment tool, dated 2/1/23, listed diagnoses for Resident #1 which included pressure ulcer, hip fracture, and osteoarthritis(inflammation of the bone and joints). The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, dressing, toilet use, and bathing, and depended completely on 2 staff for transfers. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

A Care Plan entry, dated 11/21/22, stated the resident utilized scheduled oxycodone for pain related to a pressure area to the coccyx.

A 2/16/23 Care Conference Note stated the resident requested to have nursing follow-up regarding the scheduling of her oxycodone (a narcotic pain medication).

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F 561	Continued From page 2 The February 2023 Medication Administration Record (MAR) listed an order for oxycodone/acetaminophen 5-325 milligrams (mg) 1 tab orally three times a day for pain. The MAR indicated the oxycodone was scheduled at "AM", "PM", and "HS ME" (bedtime) from 2/1/23-2/24/23 and was scheduled at 7:00 a.m., 3:00 p.m., and 11:00 p.m. from 2/25/23-2/27/23. The MAR lacked documentation the facility changed the oxycodone schedule during the period of 2/16/23 (care conference date) until 2/25/23. A 2/25/23 Nurses Note stated the resident and family desired the oxycodone to be scheduled at 7:00 a.m., 3:00 p.m., and 11:00 p.m. The facility policy "Reasonable Accommodation of Needs, Preferences", effective 5/2022, stated residents had a right to receive services with reasonable accommodation of their needs and preferences. During an interview on 4/6/23 at 10:55 a.m., the Director of Nursing (DON) stated if a concern was brought up in a care conference, she should be informed immediately. During an interview on 4/6/23 at 11:38 a.m., the Administrator stated if something was brought up in a care conference, it should be addressed right away.	F 561		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		

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F 623	Continued From page 3 resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623	1. R2 is not currently a resident of the facility. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Staff have been re-educated on the requirement for Social Services to notify the Ombudsman of all discharges from the facility. 4. Director of Social Services will audit at all discharges for the next two months to ensure that proper notification to the Ombusdan's Office has been made. Findings will be taken to QAPI for review. 5. Date of Compliance 5/6/23	

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F 623		F 623		
	Continued From page 4 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;(iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon			

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F 623		F 623		
	Continued From page 5 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review, and staff interview, the facility failed to notify the office of the State Long-Term Care Ombudsman of a resident transferred to the hospital for 1 of 1 residents reviewed for hospitalizations (Resident #2). The facility reported a census of 56 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 2/13/23 showed diagnoses for Resident #2 included hypertension, non-Alzheimer's dementia, and depression. A Progress Note dated 2/12/23 stated Resident #2 was transferred from the facility to the hospital on 2/21/23. Facility policy titled "F 622, F 623 Transfer and/or Discharge, including Against Medical Advice" indicated the resident, and/or representative (sponsor) would be provided with information in writing and in a language and manner they			

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F 623	Continued From page 6 understand prior to transfer. The policy advised to send a copy of the written information to the State Long Term Care Ombudsman. On 4/5/23 at 11:20 AM The Administrator was asked about the notice of written discharge/transfer to the hospital for Resident #2. The Administrator stated the written notice was not given because the son who is Power of Attorney for Resident #2 initiated the discharge. Written notice was not provided to Resident #2's POA or the Long Term Care Ombudsman on or after 2/21/23. On 4/6/23 at 9:00 AM the Social Services director stated the facility did not provide written notice of hospital transfers to the Ombudsman and the facility would start providing the required notices.	F 623	\
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review,	F 686	1 R5 is deceased. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Nursing staff have been re-educated on the requirement for completing all treatment requirements as ordered per physician. 4. Director of nursing/designee will audit treatment administration record to ensure a treatments are given as ordered per physician. This will be audited daily x2 weeks, then 3x weekly for x2 weeks. Findings will be taken to QAPI for review. 5. Date of Compliance 5/6/23

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F 686		F 686		

Continued From page 7

policy review, and staff interview, the facility failed to carry out treatments in order to treat pressure ulcers for 2 of 3 residents reviewed with a pressure ulcer (Residents #1 and #5). The facility reported a census of 56 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool, dated 2/1/23, stated Resident #1 admitted to the facility on 9/21/22 and listed diagnoses which included pressure ulcer, hip fracture, and osteoarthritis (inflammation of the bone and joints). The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, dressing, toilet use, and bathing, and depended completely on 2 staff for transfers. The MDS stated the resident had 1 Stage 4 pressure ulcer defined as full thickness tissue loss with exposed bone, tendon, or muscle. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

A 9/20/22 home health Discharge Summary Report stated the resident discharged from home health on 9/20/22 and was accepted to be admitted to long term care. The report stated the resident had a sacral (lower back) wound.

Care Plan entries, dated 11/4/23, stated the resident had a Stage 4 pressure ulcer and directed staff to complete treatments as ordered.

The Medication Administration Records (MARs) for October 2022-February 2023 listed an order for Santyl ointment (used to aide in wound healing) 250/gram and to apply to coccyx topically

F 686		F 686		
	Continued From page 8 one time a day for would care. The following entries were blank and lacked staff initials to indicate the completion of the treatment: 10/23/22, 10/30/22, 11/2/22, 12/19/22, 1/1/23, 1/2/23, 1/8/23, 1/24/23, 1/31/23, & 2/8/23. A 10/22/22 6:28 p.m. Orders-Administration note listed an order for Santyl ointment 250/gram with the entry "just had no time to complete". A 10/31/22 Physician Notification stated the resident's coccyx treatment was not completed on 10/15/22 and 10/22/22. An 11/18/22 Nurses Note stated the physician noted "ok" that the coccyx treatment was not completed on 11/17/22. A 2/24/23 Wound Treatment Plan stated the resident had a Stage 4 pressure ulcer to her coccyx which measured 5.1 centimeters(cm) x 6.0 cm x 0.4 cm (length x width). 2. The MDS assessment tool, dated 3/30/23, listed diagnoses for Resident #5 which included non-Alzheimer's dementia, fracture, and repeated falls. The MDS stated the resident required limited assistance of 1 staff for eating and walking and extensive assistance of 1 staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. The MDS stated the resident had 1 or more unhealed pressure ulcers and listed the resident's BIMS score as 5 out of 15, indicating severely impaired cognition. A 2/20/23 Care Plan entry stated the resident had actual impairment to the skin of the coccyx present on admission. The Care Plan did not address the resident's skin impairment to the leg.			

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F 686		F 686		

Continued From page 9

A 3/9/23 Altered Skin Integrity Notification stated the resident had a pressure wound to the anterior lower right leg measuring 2.0 cm x 2.2 cm x 0.1 cm.

The March 2023 MAR listed a 3/9/23 order for the anterior right lower leg (2 areas) to cleanse the wound and apply hydrocolloid dressing, change every 3 days and as needed until resolved. The entries for 3/27/23 and 3/30/23 were blank and lacked staff initials to indicate the completion of the treatment.

During an observation on 4/4/23 at 7:47 a.m., Resident #5 laid in bed and Staff A Certified Nursing Assistant (CNA) stated the resident had a sore on her leg from a boot she used to wear. The resident had a red sore on the inner right lower leg with a whitish center. The sore was uncovered and the resident asked for a bandage and stated the sore hurt. Staff A called in Staff B Assistant Director of Nursing (ADON) and she measured the wound on the resident's inside lower right leg as 1.9 cm x 1.8 cm. The wound bed was red with clear drainage weeping from the center. The ADON cleansed the area with wound cleanser and the resident stated "ooh, ooh, that hurts". The resident had an additional wound lower on the leg and the ADON measured this as 0.4 cm x 0.3 cm. The ADON covered the areas with a thick bandages and the resident stated it felt a lot better after being covered.

The facility policy "Wound Care Guidelines" effective 11/2021, stated the purpose of the procedure was to provide guidelines for the care of wounds and to promote healing. The policy directed staff to review the resident's care plan

F 686		F 686		

Continued From page 10 and current orders and to check the treatment order.

During an interview on 4/5/23 at 1:20 p.m., Staff C CNA stated staffing at the facility was not good. She stated she did showers but was pulled to work the floor. She stated on days she was pulled to the floor, showers did not get done. She stated it was difficult to answer call lights in a timely manner and it could take 30-45 minutes to answer the call light. She stated on one incidence she had Resident #1 in the shower and her patch was dated 3 days prior and was supposed to be changed every day or twice daily. She stated she called the Administrator in and the dressing was saturated and yellow and green drainage had leaked through.

During an interview on 4/5/23 at 1:34 p.m., Staff D CNA stated it was difficult to answer call lights in a timely manner and family members got mad. She stated Resident #1 had an open wound and some nurses would refuse to change the dressing. Staff D stated she would inform the nurses that the resident was ready for the dressing change but at times it did not get done.

During an interview on 4/5/23 at 1:54 p.m., Staff E CNA stated staffing was not good and the residents did not receive cares and it impacted them a lot. She stated residents missed showers and it was difficult to answer call lights in a timely manner. She stated restorative was not getting completed and dressing changes were missed. She stated with regard to Resident #1, there were times they could not change her when she was wet due to staffing.

During an interview on 4/6/23 at 10:55 a.m., the

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F 686	Continued From page 11 Director of Nursing (DON) stated staff should complete dressings as ordered and it was not acceptable to chart that there was no time to complete a dressing change. During an interview on 4/6/23 at 11:38 a.m., the Administrator stated there was one instance when she was called into the shower room regarding a treatment not completed and she followed up with the nurse involved. She stated she expected treatments to be completed as ordered.	F 686	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725	1. R1 is deceased. R5 is currently a resident at the facility. R5's current treatment orders were reviewed, and their care plan was reviewed. Nursing Schedule was reviewed to ensure adequate staffing to provide showers and wound care. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Nurse Managers have been re-educated on monitoring medication administration reports and treatment administration reports to make sure they are completed as ordered. Nurse Managers have been re-educated to monitor staffing for adequate levels daily. Nurse Managers will train clinical staff on expectations on providing nursing services related to wound care and bathing. 4. Director of Nursing/designee will audit bathing and wound dressing change schedules to ensure bathing and wound dressings have been completed, unless refused and documented, to be completed 3X a week for 2X week, then 2X a week for 2 weeks, then 1X a week for 4 weeks. Administrator/designee will audit staffing daily sheets for adequate staffing 3X a week for 2X week, then 2X a week for 2 weeks, then 1X a week for 4 weeks. Findings will be taken to QAPI for review. 5. Date of Compliance 5/6/23

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F 725		F 725		

Continued From page 12

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, policy review, and staff interviews, the facility failed to ensure sufficient nursing staff to provide nursing and related services for 2 of 6 residents reviewed for staffing (Resident #1 and #5). The facility reported a census of 56 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool, dated 2/1/23, stated Resident #1 admitted to the facility on 9/21/22 and listed diagnoses which included pressure ulcer, hip fracture, and osteoarthritis (inflammation of the bone and joints). The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, dressing, toilet use, and bathing, and depended completely on 2 staff for transfers. The MDS stated the resident had 1 Stage 4 pressure ulcer defined as full thickness tissue loss with exposed bone, tendon, or muscle. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

A 9/20/22 home health Discharge Summary Report stated the resident discharged from home health on 9/20/22 and was accepted to be admitted to long term care. The report stated the resident had a sacral(lower back) wound.

Care Plan entries, dated 11/4/23, stated the

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725		F 725		

Continued From page 13 resident had a Stage 4 pressure ulcer and directed staff to complete treatments as ordered.

The Medication Administration Records(MARs) for October 2022-February 2023 listed an order for Santyl ointment(used to aide in wound healing) 250/gram and to apply to coccyx topically one time a day for would care. The following entries were blank and lacked staff initials to indicate the completion of the treatment: 10/23/22, 10/30/22, 11/2/22, 12/19/22, 1/1/23, 1/2/23, 1/8/23, 1/24/23, 1/31/23, & 2/8/23.

A 10/22/22 6:28 p.m. Orders-Administration note listed an order for Santyl ointment 250/gram with the entry "just had no time to complete".

A 10/31/22 Physician Notification stated the resident's coccyx treatment was not completed on 10/15/22 and 10/22/22.

An 11/18/22 Nurses Note stated the physician noted "ok" that the coccyx treatment was not completed on 11/17/22.

A 2/24/23 Wound Treatment Plan stated the resident had a Stage 4 pressure ulcer to her coccyx which measured 5.1 centimeters (cm) x 6.0 cm x 0.4 cm (length x width).

2. The MDS assessment tool, dated 3/30/23, listed diagnoses for Resident #5 which included non-Alzheimer's dementia, fracture, and repeated falls. The MDS stated the resident required limited assistance of 1 staff for eating and walking and extensive assistance of 1 staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. The MDS stated the resident had 1 or more unhealed pressure ulcers

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F 725		F 725		

Continued From page 14 and listed the resident's BIMS score as 5 out of 15, indicating severely impaired cognition.

A 2/20/23 Care Plan entry stated the resident had actual impairment to the skin of the coccyx present on admission. The Care Plan did not address the resident's skin impairment to the leg.

A 3/9/23 Altered Skin Integrity Notification stated the resident had a pressure wound to the anterior lower right leg measuring 2.0 cm x 2.2 cm x 0.1 cm.

The March 2023 MAR listed a 3/9/23 order for the anterior right lower leg (2 areas) to cleanse the wound and apply hydrocolloid dressing, change every 3 days and as needed until resolved. The entries for 3/27/23 and 3/30/23 were blank and lacked staff initials to indicate the completion of the treatment.

During an observation on 4/4/23 at 7:47 a.m., Resident #5 laid in bed and Staff A Certified Nursing Assistant (CNA) stated the resident had a sore on her leg from a boot she used to wear. The resident had a red sore on the inner right lower leg with a whitish center. The sore was uncovered and the resident asked for a bandage and stated the sore hurt. Staff A called in Staff B Assistant Director of Nursing (ADON) and she measured the wound on the resident's inside lower right leg as 1.9 cm x 1.8 cm. The wound bed was red with clear drainage weeping from the center. The ADON cleansed the area with wound cleanser and the resident stated "ooh, ooh, that hurts". The resident had an additional wound lower on the leg and the ADON measured this as 0.4 cm x 0.3 cm. The ADON covered the areas with a thick bandages and the resident stated it

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F 725	Continued From page 15 felt a lot better after being covered. The facility policy "Nursing Services", revised 10/2022, stated the community provided adequate staffing to provide nursing and related services. The policy stated the facility would have the appropriate numbers of licensed nursing staff to provide directed services to residents as well as to assist and monitor the aides on their shifts. During an interview on 4/5/23 at 1:20 p.m., Staff C CNA stated staffing at the facility was not good. She stated she did showers but was pulled to work the floor. She stated on days she was pulled to the floor, showers did not get done. She stated it was difficult to answer call lights in a timely manner and it could take 30-45 minutes to answer the call light. She stated on one incidence she had Resident #1 in the shower and her patch was dated 3 days prior and was supposed to be changed every day or twice daily. She stated she called the Administrator in and the dressing was saturated and yellow and green drainage had leaked through. During an interview on 4/5/23 at 1:34 p.m., Staff D CNA stated it was difficult to answer call lights in a timely manner and family members got mad. She stated Resident #1 had an open wound and some nurses would refuse to change the dressing. Staff D stated she would inform the nurses that the resident was ready for the dressing change but at times it did not get done. During an interview on 4/5/23 at 1:54 p.m., Staff E CNA stated staffing was not good and the residents did not receive cares and it impacted them a lot. She stated residents missed showers and it was difficult to answer call lights in a timely	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165427	A. BUILDING _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWTON HEALTH CARE CENTER	200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208

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F 725	Continued From page 16 manner. She stated restorative was not getting completed and dressing changes were missed. She stated with regard to Resident #1, there were times they could not change her when she was wet due to staffing. During an interview on 4/6/23 at 10:55 a.m., the Director of Nursing (DON) stated staff should complete dressings as ordered and it was not acceptable to chart that there was no time to complete a dressing change. During an interview on 4/6/23 at 11:38 a.m., the Administrator stated there was one instance when she was called into the shower room regarding a treatment not completed and she followed up with the nurse involved. She stated she expected treatments to be completed as ordered.	F 725		