STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED C C O4/06/2023 NAME OF PROVIDER OR SUPPLIER NEWTON HEALTH CARE CENTER (X3) DATE SURVEY COMPLETED C Q4/06/2023 STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
NAME OF PROVIDER OR SUPPLIER NEWTON HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
NEWTON HEALTH CARE CENTER 200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)
NEWTON HEALTH CARE CENTER NEWTON, IA 50208 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
DREFLY (EACH DEFICIENCY MUST BE DRECEDED BY FULL DREETLY (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE
DEFICIENCY)
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
redefailules of Evidence and any
Correction Date: 5-6-2023 corresponding state rules of civil procedure and should be inadmissible in
and proceeding in the basis. The Facility The following deficiencies resulted from submits this plan of corrective action with
investigation of consolidate #4070FF O
#111222 C #111221 C 2 #111479 C conducted
April 3, 2023 to April 6th, 2023
action against the racility of any
Complaints #107255-C, #111252-C, #111551-C,
and #111478-C were substantiated. Statements of Deficiencies will be, taken
See code of Federal Regulations (42 CFR), Part to the facility's Quality Assurance/Assessment Committee.

PRINTED: 04/19/2023 FORM APPROVED OMB NO. 0938-0391

Self-Determination SS=D

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.

- 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 reeducated 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.

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Matthew Memmor

Administrator

4/27/23

(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:R6PP11

Facility ID: IA0639

If continuation sheet Page 1 of 17

STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMPI	
			Ì			
		165427	B. WING		04/0	06/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NEWTON HEALTH CARE CENTER				200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(=:::::::::::::::::::::::::::::::::::::	BE	(X5) COMPLETION DATE

PRINTED: 04/19/2023 FORM APPROVED

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO). 0938-0391
F 561			F 5	561		
	Continued From page	<u>.</u> 1				
	Continued From page	. I				
	0.400.40(5)(0) =1					
	§483.10(f)(8) The res					
		ctivities, including social,				
	religious, and commu	ınity activities that do not				
	interfere with the right	ts of other residents in the				
	facility.					
	This REQUIREMENT	is not met as evidenced				
	by:					
	,	ord review, policy review,				
		e facility failed to ensure a				
		carry out the right to make				
		s significant to the resident				
		viewed for resident rights				
	, ,	acility reported a census of				
	56 residents.					
	F. P					
	Findings include:					
	T. M D O.	. (1170)				
		et (MDS) assessment tool,				
		iagnoses for Resident #1				
	1	ure ulcer, hip fracture, and				
		nation of the bone and				
		ted the resident required				
	extensive assistance	of 1 staff for personal				
	hygiene, extensive as	ssistance of 2 staff for bed				
	mobility, dressing, toil	let use, and bathing, and				
	depended completely	on 2 staff for transfers.				
	The MDS listed the re	esident's Brief Interview for				
	Mental Status (BIMS)	score as 15 out of 15,				
	indicating intact cogni					
	A Care Plan entry, da	ated 11/21/22, stated the				
	_	duled oxycodone for pain				
	related to a pressure	· · · · · · · · · · · · · · · · · · ·				
	'	,				
	A 2/16/23 Care Confe	erence Note stated the				
		have nursing follow-up				
		ling of her oxycodone (a				
	narcotic pain medicat					
	l l	,				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		PLETED
			1		1 ,	С
		40-40-				
NAME OF P	ROVIDER OR SUPPLIER	165427	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	06/2023
TVAIVIL OF T	NOVIDEN ON OUT FIEN			, , ,		
NEWTON	HEALTH CARE CENTER	B		200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208		
NEWION	HEALTH CARE CENTER			14L441 O14, IA 30200		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	,		COMPLETION DATE
IAG	REGULATURY URL	LOC IDENTIF HING INFORMATION)	IAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IAIE	

PRINTED: 04/19/2023 FORM APPROVED

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO	0. 0938-0391
F 561			F 5	561		
	Continued From page	. 2				
	Continued From page	5				
	The February 2023 M	ledication Administration				
	Record (MAR) listed a	an order for				
	. ,	ophen 5-325 milligrams (mg)				
		es a day for pain. The MAR				
	_					
	_	one was scheduled at "AM",				
	"PM", and "HS ME" (I					
		as scheduled at 7:00 a.m.,				
		p.m. from 2/25/23-2/27/23.				
	The MAR lacked doc	umentation the facility				
	changed the oxycodo	ne schedule during the				
	period of 2/16/23 (car	re conference date) until				
	2/25/23.	•				
	A 2/25/23 Nurses Not	te stated the resident and				
		/codone to be scheduled at				
	7:00 a.m., 3:00 p.m.,					
	7.00 a.iii., 3.00 p.iii.,	and 11.00 p.m.				
	The feeilibe malies !!De	and the Annual detical of				
		easonable Accommodation of				
		effective 5/2022, stated				
	_	to receive services with				
	reasonable accommo	odation of their needs and				
	preferences.					
	During an interview o	n 4/6/23 at 10:55 a.m., the				
	Director of Nursing (D	OON) stated if a concern was				
		conference, she should be				
	informed immediately					
	,					
	During an interview o	n 4/6/23 at 11:38 a.m., the				
		f something was brought up				
		it should be addressed right				
	away.	it should be addressed right				
E 623	, -	Before Transfer/Discharge	F 6	202		
SS=B		_	1 0	023		
30-B	CFN(S). 400. 10(C)(3)-	-(0)(8)				
	§483.15(c)(3) Notice	hafara transfar				
	Before a facility trans	iers or discharges a				
			(X2) MULT	TIPLE CONSTRUCTION	$\overline{}$	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	NG	(X3) DATE	SURVEY
AND FLAN OF	CORRECTION	IDENTIFICATION NOWIDER.	, a Boilebin			
					(C
		165427	B. WING _		04/	06/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				200 SOUTH EIGHTH AVENUE EAST		
NEWTON	HEALTH CARE CENTE	R		NEWTON, IA 50208		
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	,	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX			COMPLETION
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
Ī				DEFICIENCY)		

PRINTED: 04/19/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 F 623 Continued From page 3 F 623 1. R2 is not currently a resident, the facility mustresident of the facility. Notify the resident and the resident's representative(s) of the transfer or discharge and 2. Current residents have the the reasons for the move in writing and in a language and manner they understand. The facility potential to be affected by must send a copy of the notice to a representative the alleged deficient of the Office of the State Long-Term Care Ombudsman. practice. Record the reasons for the transfer or 3. Staff have been redischarge in the resident's medical record in accordance with paragraph (c)(2) of this section; educated on the requirement for Social (iii) Include in the notice the items described in paragraph (c)(5) of this section. Services to notify the Ombudsman of all §483.15(c)(4) Timing of the notice. Except as specified in paragraphs (c)(4)(ii) discharges from the and (c)(8) of this section, the notice of transfer or discharge required under this section must be made facility. by the facility at least 30 days before the resident is 4. Director of Social Services transferred or discharged. Notice must be made as soon as practicable will audit at all discharges before transfer or discharge when-The safety of individuals in the facility for the next two months to (A) would be endangered under paragraph ensure that proper (c)(1)(i)(C) of this section; The health of individuals in the facility notification to the would be endangered, under paragraph Ombusdan's Office has (c)(1)(i)(D) of this section: The resident's health improves been made. Findings will sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this be taken to QAPI for section; (D) An immediate transfer or discharge is review. required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) 5. Date of Compliance 5/6/23 A resident has not resided in the facility for 30 days.

	OF DEFICIENCIES CORRECTION	(X1) IDENTIFICATIO	PROVIDER/SUPPLIER/CLIA N NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
						С
			165427	B. WING_		04/06/2023
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
NEWTON	HEALTH CARE CENTE	R			200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208	
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO

CLIVIEN	S I OIL MEDICARE & I	WEDICAID SERVICES			CIVID IVC	7. 0930-0391
F 623			F 6	523		
	Continued From page	e 4				
		its of the notice. The written				
		ragraph (c)(3) of this section				
	must include the follo					
		or transfer or discharge;				
		date of transfer or				
	` '	ation to which the resident is				
	transferred or dischar					
		of the resident's appeal				
	, ,	ame, address (mailing and				
	9	e number of the entity which				
		ts; and information on how				
	to obtain an appeal fo	orm and assistance in				
	completing the form a	and submitting the appeal				
	hearing request;	•				
	(v) The name, a	ddress (mailing and email)				
	and telephone number	er of the Office of the State				
	Long-Term Care Omb	budsman;				
	(vi) For nursing fa	acility residents with				
		opmental disabilities or				
		e mailing and email address				
		er of the agency responsible				
		advocacy of individuals with				
		lities established under Part				
	-	tal Disabilities Assistance				
	_	of 2000 (Pub. L. 106-402,				
		15001 et seq.); and (vii) For				
	-	nts with a mental disorder or				
		e mailing and email address				
	-	er of the agency responsible				
		advocacy of individuals with				
	a mental disorder est					
	Protection and Advoc	cacy for Mentally III				
	Individuals Act.					
	§483.15(c)(6) Change	on to the notice				
		ne notice changes prior to				
		or discharge, the facility				
	-	pients of the notice as soon				
	made apacto and room	oreme or are mease as seen				
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		LETED
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		405407				06/2023
NAME OF PE	ROVIDER OR SUPPLIER	165427	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	06/2023
INAME OF FE	TO VIDER OR OUT I LIER			200 SOUTH EIGHTH AVENUE EAST		
NEWTON	HEALTH CARE CENTER	R		NEWTON, IA 50208		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B		COMPLÉTION DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	2

CLIVILIX	S FUR WEDICARE & I	WEDICAID SERVICES			OIVID INC	7. 0936-0391
F 623			F 6	23		
	Continued From page	5 as practicable			ļ	
	once the updated info	ormation becomes			ļ	
	available.				ļ	
		in advance of facility closure				
	_	closure, the individual who is				
		ne facility must provide				
	written notification pri	or to the impending closure				
	to the State Survey A	gency, the Office of the			ļ	
	State Long-Term Car	e Ombudsman, residents of				
	the facility, and the re	esident representatives, as			ļ	
	well as the plan for th	e transfer and adequate			ļ	
	relocation of the resid	lents, as required at §				
	483.70(I).				ļ	
	This REQUIREMENT	is not met as evidenced				
	by:				ļ	
	Based on clinical rec	ord review, facility policy			ļ	
	review, and staff inter	view, the facility failed to			ļ	
	notify the office of the	State Long-Term Care			ļ	
	Ombudsman of a resi	ident transferred to the			ļ	
	hospital for 1 of 1 resi	idents reviewed for				
	hospitalizations (Resi	dent #2). The facility				
	reported a census of	56 residents.				
	Findings include:					
		et (MDS) Assessment tool			ļ	
		d diagnoses for Resident #2			ļ	
	- ·	n, non-Alzheimer's dementia,				
	and depression.					
	~	ed 2/12/23 stated Resident			ļ	
		om the facility to the hospital			ļ	
	on 2/21/23.					
		- 000 F 000 F				
	* * *	F 622, F 623 Transfer and/or				
		Against Medical Advice"			ļ	
		t, and/or representative				
	· · / · · ·	rovided with information in age and manner they				
	withing and in a langu	age and manner they	<u> </u>			
OTATEMENT (DE DEFICIENCIES	(M4) PROMER (AURRUSE) (AUR	(X2) MULT	PLE CONSTRUCTION	(VO) DATE	OLIDVEY.
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IG	(X3) DATE COMP	PLETED
					l ,	C
NAME OF DE	ROVIDER OR SUPPLIER	165427	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	06/2023
NAME OF F	NOVIDER OR SUFFLIER					
NEWTON	HEALTH CARE CENTER	P	ŀ	200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208		
	ALIII OAKE CENTER			11211 ON, IA 30200		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		DATE
				DEFICIENCY)		

F 623		F 623	1	
	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.			
F 686 SS=D	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. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686	R5 is deceased. Current residents have the	
	§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,		potential to be affected by the alleged deficient practice. 3. Nursing staff have been reeducated 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	165427	B. WING		04/06/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NEWTON HEALTH CARE CEN	TER		200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208	
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE

CENTER	S FOR MEDICARE & I	VIEDICAID SERVICES			OIVID INC	7. 0930-0391
F 686			F 68	6		
	Continued From page	e 7				
	. •	off interview, the facility failed				
	•	s in order to treat pressure				
	ulcers for 2 of 3 resident					
		lents #1 and #5). The facility				
	reported a census of					
	•					
	Findings include:					
		a Set (MDS) assessment				
		ated Resident #1 admitted to				
	_	and listed diagnoses which				
	included pressure ulc	nation of the bone and				
	•	ted the resident required				
	extensive assistance	•				
		ssistance of 2 staff for bed				
		let use, and bathing, and				
		on 2 staff for transfers.				
	The MDS stated the r	esident had 1 Stage 4				
	pressure ulcer define	d as full thickness tissue				
	•	ne, tendon, or muscle. The				
		ent's Brief Interview for				
		score as 15 out of 15,				
	indicating intact cogni	ilion.				
	Δ 9/20/22 home healt	th Discharge Summary				
		ident discharged from home				
	health on 9/20/22 and					
		care. The report stated the				
	resident had a sacral					
		ted 11/4/23, stated the				
	resident had a Stage					
	directed staff to comp	elete treatments as ordered.				
	The Medication Admi	nistration Records (MARs)				
		oruary 2023 listed an order				
	for Santyl ointment (u					
	,	d to apply to coccyx topically				
	J, J					<u>I</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	I ` ′	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	PLETED
						0
		165427	B. WING		04/	06/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		_		200 SOUTH EIGHTH AVENUE EAST		
NEWTON	HEALTH CARE CENTE	R		NEWTON, IA 50208		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
.,,,			1,10	DEFICIENCY)	<u>-</u>	

OLITICITY.	OT OIL MEDIO/ ILE AT	WEDIO/ ND GERVIOLO		•	JIVID IVO	. 0000-0001
F 686			F 6	686		
	Continued From page	8 one time a day for				
		wing entries were blank				
	and lacked staff initial	_				
	completion of the trea					
		//19/22, 1/1/23, 1/2/23,				
	1/8/23, 1/24/23, 1/31/	23, & 2/8/23.				
		Orders-Administration note				
		ntyl ointment 250/gram with				
	the entry "just had no	time to complete".				
		Notification stated the				
	•	atment was not completed				
	on 10/15/22 and 10/2	2/22.				
	A 44/40/00 N					
		Note stated the physician				
		occyx treatment was not				
	completed on 11/17/2	22.				
	A 0/04/00 \A/	atus and Diana at at a differ				
		eatment Plan stated the				
	•	4 pressure ulcer to her				
		red 5.1 centimeters(cm) x				
	6.0 cm x 0.4 cm (leng	gth x width).				
	0. The MD0					
		nent tool, dated 3/30/23,				
		Resident #5 which included				
		entia, fracture, and repeated				
		d the resident required				
		1 staff for eating and walking				
	and extensive assista					
	_	essing, toilet use, personal				
		. The MDS stated the				
		re unhealed pressure ulcers				
		it's BIMS score as 5 out of				
	15, indicating severely	y impaired cognition.				
	A 0/00/00 O DI					
		entry stated the resident had				
	actual impairment to t	•				
	•	. The Care Plan did not				
	address the residents	s skin impairment to the leg.				
OTATEMENT:	OF DEFICIENCIES	(V4) DDO\/(DED/QUDD\UED/QUA	(X2) MULT	IPLE CONSTRUCTION	(V2) DATE	CLIDVEV
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	NG	(X3) DATE COMP	SURVEY LETED
					(`
NAME OF D	ROVIDER OR SUPPLIER	165427	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	06/2023
INAME OF PI	NO VIDEN ON OUFFLIER					
NEWTON	HEALTH CARE CENTER	R		200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208		
(X4) ID		ATEMENT OF DEFICIENCIES	ID PREFI)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		DATE
-		- /		DEFICIENCY)		

CLIVIEN	STOR WEDICARE & I	VIEDICAID SERVICES			CIVID IVC	7. 0936-0391
F 686			F 68	6		
	Continued From page	9				
	1 3					
	A 3/9/23 Altered Skin	Integrity Notification stated				
		essure wound to the anterior				
		ring 2.0 cm x 2.2 cm x 0.1				
	cm.	ming 2.0 om x 2.2 om x 0.1				
	OIII.					
	The March 2023 MAR	R listed a 3/9/23 order for the				
		g (2 areas) to cleanse the				
	•	rocolloid dressing, change				
		needed until resolved. The				
	•	d 3/30/23 were blank and				
		indicate the completion of				
	the treatment.	indicate the completion of				
	the treatment.					
	During an observation	n on 4/4/23 at 7:47 a.m.,				
	•	ed and Staff A Certified				
		NA) stated the resident had a				
		a boot she used to wear.				
	_	ed sore on the inner right				
		sh center. The sore was				
	_	sident asked for a bandage				
		urt. Staff A called in Staff B				
		Nursing (ADON) and she				
		on the resident's inside				
		cm x 1.8 cm. The wound				
		ar drainage weeping from the				
		leansed the area with wound				
		dent stated "ooh, ooh, that				
		had an additional wound				
		the ADON measured this as				
	•	e ADON covered the areas				
		s and the resident stated it				
	felt a lot better after b					
		· ·				
	The facility policy "Wo	ound Care Guidelines"				
	effective 11/2021, sta	ted the purpose of the				
	procedure was to pro-	vide guidelines for the care				
	of wounds and to pro	mote healing. The policy				
	directed staff to review	w the resident's care plan				
			(VO) MULTIPLE	F CONCEDUCTION	T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			LETED
						0
		165427	B. WING		04/	06/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	_	
		_		200 SOUTH EIGHTH AVENUE EAST		
NEWTON	HEALTH CARE CENTER	R		NEWTON, IA 50208		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE
TAG	REGULATURY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	

OLIVILIV	OT OIL WEDIONILE &	WEDIO/ ND GERVIOLO			OIVID INC	7. 0000-0001
F 686			F 6	86		
	. •	e 10 and current orders				
	and to check the treat	tment order.				
	During an interview on 4/5/23 at 1:20 p.m., Staff					
	•	g at the facility was not good.				
		nowers but was pulled to				
		tated on days she was				
		owers did not get done. She				
	·	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	- ·				
		ged every day or twice daily.				
		I the Administrator in and the				
	drainage had leaked	ed and yellow and green				
	urairiage riau leakeu	illiougii.				
	During an interview o	n 4/5/23 at 1:34 p.m., Staff				
	•	difficult to answer call lights				
		nd family members got mad.				
	She stated Resident	#1 had an open wound and				
	some nurses would re	•				
	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.						
	dressing change but a	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					
		ing changes were missed.				
	She stated with regard to Resident #1, there were					
		change her when she was				
	wet due to staffing.					
	During an interview o	n 4/6/23 at 10:55 a.m., the				
		,				
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′	PLE CONSTRUCTION	(X3) DATE	SURVEY
		A. BUILDING			PLETED	
					(C
165427			B. WING 04/0			06/2023
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NEWTON HEALTH CADE CENTED				200 SOUTH EIGHTH AVENUE EAST		
NEWTON HEALTH CARE CENTER				NEWTON, IA 50208		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	=	(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		DATE
		•		DEFICIENCY)	ļ	

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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 725 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 insuffer 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 are 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 726 In 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 reeducated on monitoring medication administration reports to make sure they are completed as ordered. 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 dres	CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-0	391
	F 686	Continued From page Director of Nursing (Ecomplete dressings a acceptable to chart the complete a dressing of During an interview of Administrator stated the when she was called regarding a treatment followed up with their she expected treatment followed up with their she expected treatment followed. Sufficient Nursing State CFR(s): 483.35(a)(1)(1)(1)(1)(2)(2)(3)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	OON) stated staff should so ordered and it was not at there was no time to change. In 4/6/23 at 11:38 a.m., the here was one instance into the shower room and completed and she aurse involved. She stated ents to be completed as suff (2) Staff. Staff.		1. R1 is deceased. R5 is curren resident at the facility. R5's current tre orders were reviewed, and their care previewed. Nursing Schedule was reviewensure adequate staffing to provide shand wound care. 2. Current residents have the pobe affected by the alleged deficient provided and instration reports and treatment administration reports and treatment administration reports to make sure the completed as ordered. Nurse Manage been re-educated to monitor staffing for adequate levels daily. Nurse Manage train clinical staff on expectations on pursing services related to wound care bathing. 4. Director of Nursing/designee bathing and wound dressing changes to ensure bathing and wound dressing changes to ensure bathing and wound dressing been completed, unless refused and documented, to be completed 3X a we week, then 2X a week for 2 weeks, the week for 4 weeks. Administrator/desig audit staffing daily sheets for adequate 3X a week for 2X week, then 2X a week weeks, then 1X a week for 4 weeks. F will be taken to QAPI for review.	eatment clan was ewed to nowers ctential to actice. re- ey are rs have or rs will croviding e and will audit chedules ys have eek for 2X en 1X a nee will e staffing ek for 2	391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED				` ′	E CONSTRUCTION	COMPLETED	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
					DEFICIENCY)		
F 725			F 7	'25			
	Continued From page	12					
	§483.35(a)(2) Except	section, the facility must					
		nurse to serve as a charge					
	nurse on each tour of	•					
		is not met as evidenced					
	by:						
		n, clinical record review,					
		iff interviews, the facility					
		ient nursing staff to provide					
	•	ervices for 2 of 6 residents (Resident #1 and #5). The					
	facility reported a cen	,					
	lacility reported a cert	sus of 50 residents.					
	Findings include:						
	1. The Minimum Data	a 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 ulc						
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							
	•	d as full thickness tissue					
	-	ne, tendon, or muscle. The					
		nt's Brief Interview for					
	, ,	score as 15 out of 15,					
	indicating intact cogni	uon.					
	A 9/20/22 home healt	h Discharge Summary					
		ident discharged from home					
	health on 9/20/22 and	was accepted to be					
		care. The report stated the					
	resident had a sacral((lower back) wound.					
	Care Plan entries, da	ted 11/4/23, stated the					
			(X2) MULT	IPLE CO	NSTRUCTION		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		(X3	3) DATE (COMPL		
				_	C		
		165427	B. WING			_	6/2023
NAME OF PR	ROVIDER OR SUPPLIER	100421	D. WING	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	3-7/0	J. 2020
200 SOUTH EIGHTH AVENUE EAST							
NEWTON HEALTH CARE CENTER NEWTON, IA 50208							

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(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 7	25		
			,	20		
		e 13 resident had a Stage 4				
	•	rected staff to complete				
	treatments as ordered	d.				
	for October 2022-Feb for Santyl ointment(us healing) 250/gram and topically one time a day following entries were initials to indicate the 10/23/22, 10/30/22, 1 1/2/23, 1/8/23, 1/24/22. A 10/22/22 6:28 p.m. listed an order for Sar the entry "just had no A 10/31/22 Physician resident's coccyx trea on 10/15/22 and 10/2. An 11/18/22 Nurses Noted "ok" that the cocompleted on 11/17/2. A 2/24/23 Wound Tre	d to apply to coccyx ay for would care. The blank and lacked staff completion of the treatment: 1/2/22, 12/19/22, 1/1/23, 3, 1/31/23, & 2/8/23. Orders-Administration note ntyl ointment 250/gram with time to complete". Notification stated the thement was not completed 2/22.				
	6.0 cm x 0.4 cm (leng	red 5.1 centimeters (cm) x				
	0.0 GH X 0.4 GH (leng	iui A wiuui).				
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						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` ′			ATE SURVEY	
		A. BUILDIN	NG _		MPLETED	
					С	
		165427	B. WING _			04/06/2023
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE	
NEWTON HEALTH CARE CENTER					0 SOUTH EIGHTH AVENUE EAST EWTON, IA 50208	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 725			F 7	725			
	Continued From page	e 14 and listed the					
	resident's BIMS score	e as 5 out of 15,					
	indicating severely im	paired cognition.					
	A 2/20/23 Care Plan 6	entry stated the resident had					
	actual impairment to t	-					
		. The Care Plan did not					
	address the resident's	s skin impairment to the leg.					
	A 3/9/23 Altered Skin	Integrity Notification stated					
		essure wound to the anterior					
		ring 2.0 cm x 2.2 cm x 0.1					
	cm.						
	The March 2023 MAF	R listed a 3/9/23 order for the					
		g (2 areas) to cleanse the					
	•	rocolloid dressing, change					
		needed until resolved. The					
		d 3/30/23 were blank and					
lacked staff initials to indicate the completion of							
	the treatment.						
	During an observation	n on 4/4/23 at 7:47 a.m.,					
	Resident #5 laid in be	d and Staff A Certified					
	_ ,	NA) stated the resident had a					
	_	a boot she used to wear.					
		d sore on the inner right					
	_	sh center. The sore was					
		sident asked for a bandage urt. Staff A called in Staff B					
		Nursing (ADON) and she					
		on the resident's inside					
		cm x 1.8 cm. The wound					
		r drainage weeping from the					
		eansed the area with wound					
	cleanser and the resid	dent stated "ooh, ooh, that					
		nad an additional wound					
		the ADON measured this as					
		ADON covered the areas					
	with a thick bandages	and the resident stated it					
STATEMENT OF DECICIENCIES (V4) PROVIDED/SUBDLED/OLIA		(X2) MULT	TIPLE	CONSTRUCTION	()(0) DATE	0115) (5) (
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII	ING _		(X3) DATE : COMPL		
						c)
		165427	B. WING _			04/0	06/2023
NAME OF P	ROVIDER OR SUPPLIER		Ī	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		_	J		00 SOUTH EIGHTH AVENUE EAST		
NEWTON HEALTH CARE CENTER NEWTON, IA 50208							

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200 SOUTH EIGHTH AVENUE EAST NEWTON HEALTH CARE CENTER NEWTON, IA 50208						
NAME OF PR	ROVIDER OR SUPPLIER	103421	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-7/0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE COMPL	LETED
	have the appropriate staff to provide directs well as to assist and r shifts. During an interview of C CNA stated staffing She stated she did sh work the floor. She st pulled to the floor, she stated it was difficult to timely manner and it canswer the call light. incidence she had Reher patch was dated supposed to be changed She stated she called dressing was saturated drainage had leaked to During an interview of D CNA stated it was din a timely manner and She stated Resident as some nurses would reduce that the reside dressing change but a During an interview of E CNA stated staffing residents did not receive them a lot. She stated and it was difficult to a DEFICIENCIES	sident #1 in the shower and a days prior and was ged every day or twice daily. The Administrator in and the ed and yellow and green through. In 4/5/23 at 1:34 p.m., Staff difficult to answer call lights d family members got mad. If had an open wound and efuse to change the ed she would inform the ent was ready for the at times it did not get done. In 4/5/23 at 1:54 p.m., Staff was not good and the ive cares and it impacted d residents missed showers answer call lights in a timely	` '		COMPL	LETED
	felt a lot better after be The facility policy "Nu 10/2022, stated the co	rsing Services", revised				
F 725	Continued From page	: 15	F 7	25		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 725 Continued From page 16 manner. She stated F 725 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.