DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165297	A. BUILDING _____ B. WING _____	C 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HAMPTON NURSING & REHAB CE	703 SOUTH FOURTH AVENUE NEW HAMPTON, IA 50659

(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 1·29·25 ✓ JFS The following deficiencies resulted from an investigation of facility complaints #124746-C and #125376-C and facility abuse investigations #124691-A, #124693-A, #124736-M and #125793-A conducted January 3, 2025 thru January 10, 2025. Complaints #124746-C & #125376-C were substantiated. Findings of intakes #124691-A, #124693-A, #124736-M, and #125793-A will be sent under a different cover at a later date. The New Hampton Nursing and Rehabilitation was not in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and facility policy review, the facility failed to maintain call lights in reach for 1 of 4 residents reviewed (Resident #2). The facility identified a census of 24 residents. Findings include:	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rori Hanson, TITLE: Administrative Assistant, (X6) DATE: 1·29·25

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 558	Continued From page 1 An observation and interview 1.3.25 at 1:30 p.m. revealed Resident #2 positioned in his wheel chair in his room as he called out for assistance. Upon entry the resident requested to go to bed at which time an observation revealed one (1) call light wrapped around the bottom of a positioning bar on the left side of his bed. The other call light positioned across the cushion and under an unknown item of his easy chair. The Surveyor turned on the call light. At 1:40 p.m. Staff B, Certified Nursing Assistant (CNA) and Staff C, CNA responded and confirmed the cal lights were out of reach. During an interview 1.3.24 at 3:38 p.m. a family member confirmed during his regular visits to Resident #2 he observed the call lights out of reach on several occasions.	F 558		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		

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by:
Based on clinical record review, resident interview, family interview, staff interview, and facility policy/procedure review the facility failed to provide an environment free from physical assault and physical injury for 2 residents reviewed (Resident #1 and Resident #2). The facility reported a census of 24 residents.

Findings include:

1. A Minimum Data Set (MDS) form dated 10.24.24 indicated Resident #1 had diagnoses that included Cervical Spinal Fusion, Cervical Disc Disorder with Myopathy, malnutrition, Anemia, Heart Failure (HF), Coronary Artery Disease, and Atrial Fibrillation (AF). The assessment indicated the Resident had the ability to make himself understood and understand others, with a Brief Interview for Mental Status (BIMS) score of 7 out f 10 (severely impaired cognitive skills), no delirium/moods or behaviors, non-ambulatory, dependent on staff with lower body dressing and undressing and transfers, required substantial/maximum assistance of staff with toileting hygiene, dressing and undressing his upper body, and personal hygiene.

A Care Plan identified the following Focus areas and Interventions as dated:

a. Resident's ability for completion of activities of daily living (ADL's) deteriorated. (revised 12.31.20)
1. Assistance with morning (am) and evening (p.m.) cares. (initiated 3.23.21)
b. At risk for skin breakdown related to incontinence, HF and malnutrition. (initiated 12.31.20 and revised 11.7.24)

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F 600	Continued From page 3 1. History of skin tears. (revised 11.7.20) c. Resident with a skin tear of the right forearm, left 3rd finger and left elbow. (initiated and revised 11.7.24) 1. Inform/instruction to staff of causative factors and measures of prevention to skin tears. (initiated 11.7.24) An Incident Report form dated 11.5.24 at 8:45 p.m. indicated the nurse had been called to the resident's room by a Certified Nursing Assistant (CNA) as he received a skin tear to the right forearm in the shape of a "U" that measured 24 centimeters (cm) from one (1) end to the other. The resident also sustained a small skin tear to his left upper elbow that measured approximately 3 cm and a small skin tear to his left hand between the 3rd and 4th finger that measured approximately 1.3 cm. During an interview 1.3.24 at 2:46 p.m. Staff A, Certified Nursing Assistant (CNA) confirmed she worked 11.5.24 from 2 p.m. until 10 p.m. but had not been directly assigned to care for the resident. At approximately 3 ish she brought a snack to his room while she observed him positioned in his recliner. At that time he wore his short sleeved white t-shirt and plaid long sleeved shirt. That staff member could not recall if at that time had been when herself and Staff D, CNA or later transferred him to bed per an assistive lift device and laid him down, removed his pants and offered him his oxygen which he refused. The staff member indicated at no time during the transfer that occurred that evening the resident hit his arm, said ouch, and/or any blood had been noted on his person or the recliner chair. The staff member, Staff A, indicated the next time	F 600		

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she had any contact with the resident had been around 8:30 p.m. when she went to look for the nurse to have retrieved a cream for another resident when she found the nurse, along with Staff E, CNA with the resident, still positioned in bed, covered up with a blanket to his waist, with the white t-shirt on but then with a bandage over his arm but denied any conversation about the resident's arm rather informed the nurse about the need for the cream and left the room.

Staff A confirmed she worked with Staff E prior to the above stated event and observed an incident with Resident #2 approximately one (1) week prior at which time she knocked on the resident's door, entered, and observed Staff E as she held the resident's wrists because he had not wanted to get cleaned up by Staff F, CNA who also had been present. Staff A indicated it had been obvious the resident had not been happy about having his hands held because he tried to bite Staff E at which time she appeared mad as noted by her firm facial affect and how she talked to the resident with an elevated tone of voice. Staff A denied having heard any threats by Staff E however when she entered the room Staff E let go of the resident's wrists, grabbed the linens and left the room. Staff F and Staff A remained in the resident's room and covered his left arm with a towel due to the blood oozing from a noted new skin tear. The resident presented as upset related to what occurred with Staff E but showed no signs of having been combative with Staff E. The resident informed Staff A that Staff E twisted his wrist during the above stated encounter.

Staff A confirmed from her experience Staff E failed to handle the situation correctly because when a resident refused cares staff had been

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directed to walk away and absolutely not grab and/or restrain a resident's wrists.

During an interview 1.9.24 at 4:38 p.m. Staff D confirmed she assisted the resident to bed the night of the injury along with Staff A at which time he had not been combative at all. The staff members kept the resident in his clothes, she noted no signs of bleeding and the resident never complained of pain.

Staff D then confirmed she worked with Staff E within days after the resident sustained his skin tear at which time the Resident yelled at Staff E. The staff member could not recall all that was said but he presented as upset because he said she was the one who caused the skin tear to his arm. During this interaction Staff E yelled back at the resident in an angry tone and verbalized it had not been her fault.

During an interview 1.7.24 at 2:30 p.m. a family member indicated the resident told her three (3) nights in a row Staff E looked at the resident's bottom for sores. On the fourth night, the night of the election, the resident refused because he wanted to watch the results. The family member indicated the resident told her all of a sudden the staff member's face appeared viscous, further described as stern and she grabbed and twisted his arm and said your going to do this as she laid almost right on him. The resident confirmed she restrained him with her hands which made him angry and caused a feeling of helplessness. The resident indicated he yelled for help and said, no, and he went over all of the injuries he sustained during that encounter which presented as scars, showed the surveyor the scars.

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Per the family member she received a call on 11.5.24 at 11:27 p.m. at which time the night nurse apologized profusely because the male nurse should have called her at the time of the incident because the resident had been crying in pain. The family member arrived at the facility around 11:55 p.m. when the night nurse came into check the resident's blood pressure as he became combative and said "Oh I thought you were that bitch coming after me."

2. An MDS assessment form dated 8.22.24 indicated Resident #2 with diagnoses that included a Traumatic Brain Injury (TBI), absence of a right hip joint, Osteoarthritis, Obesity, Combined Systolic and Diastolic Heart Failure, and Chronic Respiratory Failure. The assessment indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 (cognitively intact) and with no Delirium, behaviors, or moods. The assessment indicated the Resident as non-ambulatory, dependent on staff with transfers and personal hygiene.

A Care Plan addressed the following Focus areas and Interventions as dated:

a. The Resident's ability to have completed ADL's had been deteriorated related to pain, a wound and a TBI. (revised 12.15.23)
1. Provision of assistance with a.m. and p.m. cares. (initiated 12.25.24)
b. At risk for falls. (initiated 12.15.23 and revised 11.7.24)
1. Non-ambulatory. (initiated 1.12.24)
2. Transferred with 2 staff assistance and a sit and stand lift device. (initiated 12.15.23 and revised 1.9.25)

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F 600	Continued From page 7 An Incident Report dated 10.25.24 at 10:00 p.m. indicated the nurse was called to the Resident's room and found the resident positioned in bed with a skin tear on his left forearm. The staff reported the Resident had been hitting and verbally abusive during cares. The Resident reported the girls tried to kill him and asked why the facility hired staff like that as he had to defend himself. A Non-Pressure Skin Condition Report dated 10.25.24 indicated the Resident sustained a skin tear on his left wrist that measure five (5) cm in a "Z" form which contained a moderate amount of serosanguinous drainage. A Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 7.2024 indicated the Policy Statement included the following: All residents had the right to have been free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		

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F 609	Continued From page 8 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, family interview, staff interview, and facility policy and procedures review the facility failed to provide an environment free from physical assault/physical injury and failed to report the suspected abuse to the State Agency in a timely manner as required for 2 residents reviewed (Resident #1 and Resident #2). The facility reported a census of 24 residents. Findings include: A MDS assessment form dated 8.22.24 indicated Resident #2 with diagnosis that included a Traumatic Brain Injury (TBI), absence of a right hip joint, Osteoarthritis, Obesity, Combined Systolic and Diastolic Heart Failure and Chronic	F 609		

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Respiratory Failure. The assessment indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 (cognitively intact) and with no Delirium, behaviors or moods. The assessment indicated the Resident as non-ambulatory, dependent on staff with transfers and personal hygiene.

A Care Plan addressed the following Focus areas and Interventions as dated:

a. The Resident's ability to have completed ADL's had been deteriorated related to pain, a wound and a TBI. (revised 12.15.23)
1. Provision of assistance with a.m. and p.m. cares. (initiated 12.25.24)
b. At risk for falls. (initiated 12.15.23 and revised 11.7.24)
1. Non-ambulatory. (initiated 1.12.24)
2. Transferred with 2 staff assistance and a sit and stand lift device. (initiated 12.15.23 and revised 1.9.25)

An Incident Report dated 10.25.24 at 10:00 p.m. indicated the nurse as called to the Resident's room and found the resident positioned in bed with a skin tear on his left forearm. The staff reported the Resident had been hitting and verbally abusive during cares. The Resident reported the girls tried to kill him and asked why the facility hire staff like that as he had to defend himself.

A Non-Pressure Skin Condition Report dated 10.25.24 indicated the Resident sustained a skin tear on his left wrist that measure five (5) cm in a "Z" form which contained a moderate amount of serosanguinous drainage.

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F 609	Continued From page 10 During an interview 1.7.25 at 1:11 p.m. Staff F, CNA confirmed she had been present during the situation with the Resident and she knew the incident had not been reported. The staff member confirmed she had been present with Staff E when the Resident sustained his skin tear as they assisted him with p.m. cares while positioned in his wheel chair but perineal cares had been performed while he stood in the lift device for the transfer. The staff member recalled as she cleaned him and Staff E controlled the lift device he said enough, enough as he routinely disliked the process due to pain. Staff F continued to clean him up due to the dried bowl movement on his buttocks. Staff F denied having known what Staff E said to him but she noted him as he swatted Staff E and eventually called her a Bitch. After proper cares had been performed the staff members positioned him in bed as Staff E said stuff to him like stop that verbiage and what would your family think in a really bad tone further defined as kind of yelling/loud and with a stern facial affect which upset the Resident more. As Staff F tried to clean the Resident's anterior perineal area Staff E stood by his head and he tried to swat at her again. Staff E then grabbed his forearms bilaterally and he said let go of me, let go of me. At this time he started kicking as she restrained his arms. At that time Staff A entered the room Staff F said they are done and Staff E left the room and that had been when they noted his arm as it bled. The Resident stated she scratched me, she scratched me. The staff members calmed him down, put a wet washcloth on it, situated him and left the room. Staff F described the skin tear (ST) as in a straight line which bled pretty good. Staff E tried	F 609		

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to blame the ST on the lift device but that could not have been the case because they would have noted blood and when Staff F first observed the site it had just begun to bleed at a pretty good clip. Staff F indicated she would not have allowed Staff E to care for any of her family members due to her tone she used and confirmed she should not have restrained the Resident rather she should have stepped away.

During an interview 1.9.25 at 1:04 p.m. Staff I, Registered Nurse (RN) confirmed she worked the evening the Resident sustained his ST when she received a walkie message from an unknown staff member who reported the Resident as combative and they required assistance. When she entered she noted the Resident as he yelled at Staff E and directed Staff I to remove her from his room with an adamant affect due to her physical behavior. Staff I requested Staff E to leave as she treated the ST.

During an interview 1.7.25 at 3:49 p.m. the Director of Nursing (DON) indicated she never thought to report the skin tear injury from Resident #2 following the same type of injury to Resident #1 approximately 10 days later that both occurred by Staff E, CNA. The DON indicated when Staff G, RN and Staff H, LPN called her and reported the injury to Resident #1 they never gave any indication there would have been a suspicion for abuse. As the situation had been further described to the DON during the investigation the DON just shook her head up and down in the motion of yes and no but failed to directly answer the question.

A Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy

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F 609	Continued From page 12 dated 7.2024 indicated the Training of Employees segment included the following: The training educated staff on: (a) activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (b) procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; and (c) management of situations in which a higher risk for abuse to occur (i.e.: dementia, behaviors, mental health diagnoses, etc.) and resident abuse prevention.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, family interview, staff interview, and facility policy and procedures review the facility	F 610		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 13	F 610		

failed to provide an environment free from physical assault/physical injury and investigate potential abuse as required by Federal regulations for 2 residents reviewed (Resident #1 and Resident #2). The facility reported a census of 24 residents.

Findings include:

1. A Minimum Data Set (MDS) form dated 10.24.24 indicated Resident #1 had diagnoses that included Cervical Spinal Fusion, Cervical Disc Disorder with Myopathy, malnutrition, Anemia, Heart Failure (HF), Coronary Artery Disease, and Atrial Fibrillation (AF). The assessment indicated the Resident had the ability to make himself understood and understand others, with a Brief Interview for Mental Status (BIMS) score of 7 out f 10 (severely impaired cognitive skills), no delirium/moods or behaviors, non-ambulatory, dependent on staff with lower body dressing and undressing and transfers, required substantial/maximum assistance of staff with toileting hygiene, dressing and undressing his upper body, and personal hygiene.

A Care Plan identified the following Focus areas and Interventions as dated:

a. Resident's ability for completion of activities of daily living (ADL's) deteriorated. (revised 12.31.20)
1. Assistance with morning (am) and evening (p.m.) cares. (initiated 3.23.21)
b. At risk for skin breakdown related to incontinence, HF and malnutrition. (initiated 12.31.20 and revised 11.7.24)
1. History of skin tears. (revised 11.7.20)
c. Resident with a skin ear of the right

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F 610	Continued From page 14 forearm, left 3rd finger and left elbow. (initiated and revised 11.7.24) 1. Inform/instruction to staff of causative factors and measures of prevention to skin tears. (initiated 11.7.24) An Incident Report form dated 11.5.24 at 8:45 p.m. indicated the nurse had been called to the resident's room by a Certified Nursing Assistant (CNA) as he received a skin tear to the right forearm in the shape of a "U" that measured 24 centimeters (cm) from one (1) end to the other. The resident also sustained a small skin tear to his left upper elbow that measured approximately 3 cm and a small skin tear to his left hand between the 3rd and 4th finger that measured approximately 1.3 cm. During an interview 1.3.24 at 2:46 p.m. Staff A, Certified Nursing Assistant (CNA) confirmed she worked 11.5.24 from 2 p.m. until 10 p.m. but had not been directly assigned to care for the resident. At approximately 3 ish she brought a snack to his room while she observed him positioned in his recliner. At that time he wore his short sleeved white t-shirt and plaid long sleeved shirt. That staff member could not recall if at that time had been when herself and Staff D, CNA or later transferred him to bed per an assistive lift device and laid him down, removed his pants, and offered him his oxygen which he refused. The staff member indicated at no time during the transfer that occurred that evening the resident hit his arm, said ouch, and/or any blood had been noted on his person or the recliner chair. The staff member indicated the next time she had any contact with the resident had been around 8:30 p.m. when she went to look for the nurse to	F 610		

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retrieved a cream for another resident when she found the nurse, along with Staff E, CNA with the resident, still positioned in bed, covered up with a blanket to his waist, with the white t-shirt on but then with a bandage over his arm but denied any conversation about the resident's arm rather informed the nurse about the need for the cream and left the room.

The staff member confirmed she worked with Staff E prior to the above stated event and observed an incident with Resident #2 approximately one (1) week prior at which time she knocked on the resident's door, entered, and observed Staff E as she held the resident's wrists because he had not wanted to get cleaned up by Staff F, CNA who also had been present. Staff A indicated it had been obvious the resident had not been happy about having his hands held because he tried to bite Staff E at which time she appeared mad as noted by her firm facial affect and how she talked to the resident with an elevated tone of voice. Staff A denied having heard any threats by Staff E however when she entered the room Staff E let go of the resident's wrists, grabbed the linens and left the room. Staff F and Staff A remained in the resident's room and covered his left arm with a towel due to the blood oozing from a noted new skin tear. The resident presented as upset related to what occurred with Staff E but showed no signs of having been combative with Staff E. The resident informed Staff A that Staff E twisted his wrist during the above stated encounter.

Staff A confirmed from her experience Staff E failed to handle the situation correctly because when a resident refused cares staff had been directed to walk away and absolutely not grab

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and/or restrain a resident's wrists.

During an interview 1.9.24 at 4:38 p.m. Staff D confirmed she assisted the resident to bed the night of the injury along with Staff A at which time he had not been combative at all. The staff members kept the resident in his clothes, she noted no signs of bleeding and the resident never complained of pain. Staff D then confirmed she worked with Staff E within days after the resident sustained his skin tear at which time the Resident yelled at Staff E. The staff member could not recall all that was said but he presented as upset because he said she was the one who caused the skin tear to his arm. During this interaction Staff E yelled back at the resident in an angry tone and verbalized it had not been her fault.

During an interview 1.7.24 at 2:30 p.m. a family member indicated the resident told her three (3) nights in a row Staff E looked at the resident's bottom for sores. On the fourth night, the night of the election, the resident refused because he wanted to watch the results. The family member indicated the resident told her all of a sudden the staff member's face appeared viscous, further described as stern and she grabbed and twisted his arm and said your going to do this, as she laid almost right on him. The resident confirmed she restrained him with her hands which made him angry and caused a feeling of helplessness. The resident indicated he yelled for help and said, no, and he went over all of the injuries he sustained during that encounter which presented as scars, showed the surveyor the scars.

Per the family member she received a call on 11.5.24 at 11:27 p.m. at which time the night nurse apologized profusely

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because the male nurse should have called her at the time of the incident because the resident had been crying in pain. The family member arrived at the facility around 11:55 p.m. when the night nurse came in to check the resident's blood pressure as he became combative and said "Oh I thought you were that bitch coming after me."

2. A MDS assessment form dated 8.22.24 indicated Resident #2 with diagnoses that included a Traumatic Brain Injury (TBI), absence of a right hip joint, Osteoarthritis, Obesity, Combined Systolic and Diastolic Heart Failure, and Chronic Respiratory Failure. The assessment indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 (cognitively intact) and with no Delirium, behaviors, or moods. The assessment indicated the Resident as non-ambulatory, dependent on staff with transfers and personal hygiene.

A Care Plan addressed the following Focus areas and Interventions as dated:

a. The Resident's ability to have completed ADL's had been deteriorated related to pain, a wound and a TBI. (revised 12.15.23)
1. Provision of assistance with a.m. and p.m. cares. (initiated 12.25.24)
b. At risk for falls. (initiated 12.15.23 and revised 11.7.24)
1. Non-ambulatory. (initiated 1.12.24)
2. Transferred with 2 staff assistance and a sit and stand lift device. (initiated 12.15.23 and revised 1.9.25)

An Incident Report dated 10.25.24 at 10:00 p.m. indicated the nurse was called to the Resident's room and found the resident positioned in bed

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with a skin tear on his left forearm. The staff reported the Resident had been hitting and verbally abusive during cares. The Resident reported the girls tried to kill him and asked why the facility hired staff like that as he had to defend himself.

A Non-Pressure Skin Condition Report dated 10.25.24 indicated the Resident sustained a skin tear on his left wrist that measure five (5) cm in a "Z" form which contained a moderate amount of serosanguinous drainage. During an interview 1.7.25 at 3:49 p.m. the Director of Nursing (DON) indicated she never thought to report the skin tear injury from Resident #2 following the same type of injury to Resident #1 approximately 10 days later that both occurred by Staff E, CNA. The DON indicated when Staff G, RN and Staff H, LPN called her and reported the injury to Resident #1 they never gave any indication there would have been a suspicion for abuse to be investigated.

A Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 7.2024 indicated the Key Definitions segment included the following:

A physical injury to, or injury at a variance with the history given of the injury, or unreasonable confinement, unreasonable punishment, or assault of a dependent adult which involved a breach of skill, care, and learned ordinarily exercised by a caretaker in similar circumstances. "Assault of a dependent adult" meant the commission of any act which generally intended to cause pain or injury to a dependent adult, or which generally intended to result in physical contact which would had been

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F 610	Continued From page 19 considered by a reasonable person to have been insulting or offensive or any act which intended to have placed another in fear of immediate physical contact which would have been painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act.	F 610		
F 725 SS=E	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 §483.71. §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. §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:	F 725		

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F 725	Continued From page 20 Based on observation, resident interview, family interview, staff interview, Resident Council Minutes, and facility policy review, the facility failed to answer resident call lights in a timely manner and within the required 15 minute time frame. (Resident #2, #4 and #5). The facility identified a census of 24 residents. Findings include: During an interview 1.9.25 at 4:05 p.m., Resident #4, identified by the facility as interviewable, indicated last night she timed her call light being on over one (1) hour as she used the clock on the wall in her room to watch the time which made her feel unwanted. During an interview 1.9.25 at 4:01 p.m., Resident #5, identified by the facility as interviewable, indicated he timed his call light being on for up to 1/2 hour as he used the clock on the wall in his room to watch the time which pissed him off. During an interview 1.3.24 at 3:38 p.m. a family member confirmed he timed the call light being on for Resident #2 for 45 minutes to 1 hour at various times but especially at meal times. During an interview 1.9.25 at 3:11 p.m., Staff A, Certified Nursing Assistant (CNA) indicated staff answered resident call lights within 15 minutes unless they were tied up in a residents room who required two (2) staff assistance. According to a form (not dated) the facility management staff identified 9 of 24 residents who required 2 staff to assist with personal cares.	F 725		

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F 725	Continued From page 21 Review of the facilities Resident Council Minutes revealed residents verbalized concerns with slow staff response to call lights on 12.31.24. A Call Light Response policy effective 10.31.24 indicated the Objective as an assurance of a timely and efficient response to resident call lights which enhanced resident safety and satisfaction. The policy listed the response time as within 15 minutes of activation.	F 725		

New Hampton Nursing and Rehabilitation Center

703 South 4th Ave.

New Hampton, IA 50659

Date survey completed: 01/10/2025

Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

F558

Resident #2 will have the call light placed in a visible area within reach. A nursing in-service will be held by the clinical nurse consultant on 01/29/2025 to re-educate all nursing staff on call light placement and response.

Placement of call lights will be monitored by the Director of Nursing or designee on walking rounds. Identified concerns will be addressed immediately and shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date complete: 01/29/2025

F600

Residents will be free from abuse. Resident #2 care plan was updated on 11/07/2024 to address interventions for staff to attempt when resistive to cares. A nursing in-service was held on 11/07/2024 with all nursing staff to review interventions for caring for any residents with dementia and behaviors. All staff were re-educated on the abuse policy during an all-staff in-service on 11/07/2024. Staff not able to attend this in-service completed on-line abuse education by 11/19/2024.

Administrator or designee to investigate all allegations of abuse. Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date complete: 01/11/2025

F609

All allegations of abuse will be reported as required by state law and facility policy. On 11/07/2024 the clinical nurse consultant reviewed the facility's Abuse Policy and reporting guidelines with all staff during an all-staff in-service. Staff unable to attend completed an on-line abuse education by 11/19/2024.

Administrator or designee will review all allegations of abuse for timely reporting. Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date complete: 01/11/2025

F610

All allegations of abuse will be investigated by the administrator or designee as required by state law and facility policy. On 11/07/2024 the clinical nurse consultant reviewed the facility abuse policy with the administrator, Director of Nursing and on-call nurses. On 11/07/2024 the clinical nurse consultant reviewed CMS exhibits 358 and 359 with the administrator, Director of Nursing, and on-call nursing staff. CMS exhibits 358 and 359 will be used to guide any future investigations into allegations of abuse.

All investigations completed for allegations of abuse will be reviewed quarterly at the QAPI meeting. Recommendations for further corrective action will be discussed and implemented as needed.

Date complete: 01/11/2025

F725

The clinical nurse consultant will re-educate all nursing staff regarding timely call-light response on 01/29/2025. Daily call light audits will be conducted by the Director of Nursing or designee daily for 2 weeks. Ongoing call light audits will be conducted monthly by the Director of Nursing or designee. The activity director or administrator will address call lights with residents during resident council meetings monthly.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date complete: 01/29/2025