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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165525	A. BUILDING B. WING	06/25/2026

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

(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
F0000 Ok ✓ Lg	INITIAL COMMENTS Correction date: 7/20/2026 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaint #2672150-C, and facility reported incident #2995779-I, conducted June 22, 2026 to June 25, 2026. Complaint #2672150-C resulted in no deficiency. Facility reported incident #2995779-I resulted in no deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, observations, staff interviews, and policy review the facility failed to provide professional standards of care by not providing treatments per physician orders for 2 of 2 (Residents #30, #3). The facility reported a census of 47 residents. Findings include: 1. Resident #30's (Minimum Data Set) MDS Assessment dated 4/23/26 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment. The	F0658		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE ✓
Helene Stringham	Administrator	7/16/26

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F0658 SS = D	Continued from page 1 document coded the resident required total assistance for toileting hygiene and had an indwelling catheter. The Care Plan, revised 4/8/26, identified a problem area related to the resident's suprapubic catheter (initiated 4/8/26) provided staff interventions of changing the catheter bag as ordered and providing catheter care as per facility policy. The clinical record's Physician Orders identified an order to clean the suprapubic site with soap and water, pat dry, daily, then apply split gauze to the suprapubic site, every day shift for prevention purposes with a start date of 5/1/26. On 6/24/26 at 7:15 AM Staff D, Registered Nurse (RN), stated she placed the resident's split gauze in the resident's room as it will get placed when the resident's peri care/catheter care was completed. On 6/24/26 at 10:45 AM when questioned about Resident #3's suprapubic catheter treatment, Staff D stated she normally placed the split gauze at the suprapubic site, but let them (referring to the Certified Nursing Assistants (CNAs)) do it today as they were completing peri care/catheter care. With the request of whether the resident had a split gauze present, Staff D assessed Resident #3's suprapubic insertion site and stated the staff did not place the split gauze and didn't know why they didn't. 2. Resident #3's MDS Assessment dated 4/23/26 revealed the resident had a BIMS score of 14/15 indicating normal cognition. The document coded the resident required substantial/maximal assistance for toileting hygiene and had an indwelling catheter. The Care Plan, revised 4/23/26, identified the problem area related to the suprapubic catheter (revised 4/23/26) contained staff interventions for changing catheter as ordered, and to report signs and symptoms of a urinary tract infection (UTI). The clinical record's Physician Orders revealed an order for split gauze to the suprapubic catheter every day and every evening shift. 1.) cleanse with soap and water around the site, 2.) place split gauze, 3.) secure with a start date of 3/12/2026. On 6/24/26 at 7:15 AM Staff D stated she placed the resident's split gauze in the resident's room as it will get placed when the resident's peri care/catheter care was completed. On 6/24/26 at 10:45 AM Staff D stated she normally	F0658		

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F0658 SS = D	Continued from page 2 placed the gauze pad but since the CNAs were completing peri/catheter cares she let them do it. On 6/24/26 at 11:00 AM Staff B, CNA, completed catheter care for Resident #3. During the observation Staff B removed a saturated split gauze from the insertion area with the resident voicing discomfort. The staff questioned if the resident had pain and the resident confirmed discomfort. When questioned further about the pain, the resident indicated it was no worse than normal. Upon completion of cleansing the site with disposable wipes, Staff B opened the split gauze package and placed the split gauze at the insertion site. On 6/24/26 at 11:15 AM when asked about the placement of the split sponge, Staff B responded that he had never done that and wasn't really sure about what he was doing. The staff stated the nurse normally placed the split gauze at the insertion site, but the nurse had instructed him to do so when finished with the catheter care. On 6/24/26 at 2:13 PM the Director of Nursing (DON) stated a physician's order regarding the care of the insertion site should be completed by the nurse not a CNA. The staff stated if the resident had complained of discomfort with the removal of the saturated gauze, a nurse's assessment should be completed to ensure there has not been a change in the status of the insertion site. The DON expected a physician's order should be completed by a nurse. On 6/24/26 at 2:40 PM the Administrator expected the nurses to complete physician orders. The facility's Medication Orders, dated 2026, revealed that medications should be administered only upon the signed order of a person lawfully authorized to do so. The policy did not address a nurse directing a CNA to administer a treatment. The facility's Job Description: CNA, Revised 5/15/21, disclosed the CNAs apply skills in routine basic nursing, personal care and restorative services.	F0658		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to	F0880		

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F0880 SS = D	Continued from page 3 help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880		

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F0880 SS = D	Continued from page 4 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, staff interviews, and policy review the facility failed to maintain infection control practices for 3 of 4 residents reviewed (Residents #10, #3, and #30). The facility failed to perform hand hygiene and change gloves when completing resident cares, failed to ensure use of enhanced barrier precautions (EBP) when required, and failed to maintain a catheter bag off the floor. The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #10, dated 5/7/26, included diagnoses of stroke and right sided hemiplegia (paralysis of 1 side of the body). The MDS identified the resident was dependent on staff for toileting hygiene and always incontinent of bladder and frequently incontinent of bowel. A Brief Interview for Mental Status (BIMS) Score of 15, indicating no cognitive impairment for decision-making. Observation on 6/22/2026 at 11:42 AM, with Resident #10 lying in bed, Staff A, Certified Nurse Aide (CNA) applied gloves, removed the brief, cleansed the groin and scrotum, and turned the resident to his side and cleansed the buttocks. Staff A proceeded with the same gloved hands and applied a new brief, touched the resident's bedding, tied up the trash bag, and then removed her gloves. Staff A failed to perform hand hygiene, applied new gloves, and then applied the resident's braces to feet/legs, shorts and shoes. 2. Resident #3's MDS Assessment dated 4/23/26	F0880		

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F0880 SS = D	Continued from page 5 revealed the resident had a BIMS score of 14/15 indicating normal cognition. The document coded the resident required substantial/maximal assistance for toileting hygiene and had an indwelling catheter. The Care Plan revised 4/23/26 identified EBP related to a suprapubic catheter as a problem area (4/23/26) with staff interventions to complete hand hygiene prior to and after cares and follow the precautions instituted during high contact activities. A problem area of supra pubic catheter (revised 4/23/26) contained staff interventions for changing catheter as ordered, and report signs and symptoms of a urinary tract infection (UTI). Observed on 6/22/26 at 11:39 AM Resident #3's catheter bag hanging from a bookcase without a dignity bag. The bag was at the height of his bladder. Observed an EBP sign on the resident's door, personal protective equipment (PPE) outside the door, and covered trash cans. Observed on 6/23/26 at 8:00 AM Resident #3's catheter bag hanging from the bookcase without a dignity bag. Continuous observation on 6/24/26 at 11:00 AM of Staff B, CNA, completing catheter care for Resident #3 revealed the following: A. Staff B donned a gown, entered the resident's room, and donned gloves without completing hand hygiene. B. Staff B gathered the canister to empty the catheter bag, an alcohol wipe, and returned to the resident's chair side. C. The staff held the canister with the left hand, removed the drain spout with the right, and emptied the catheter into the canister. The staff placed the canister on the floor, wiped the drainage tube with an alcohol wipe, threw the trash away, emptied the canister into the toilet and placed it on the toilet seat. D. Staff B changed his gloves without hand hygiene. E. Staff B proceeded to use a clean canister to obtain water from the sink to fill the dirty canister, rinsed out the dirty canister and emptied it into the toilet; each time the staff obtained clean water, the dirty canister was placed on the toilet seat until completed and the canisters were placed in separate bags for storage.	F0880		

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F0880 SS = D	Continued from page 6 F. The staff changed his gloves without hand hygiene. G. Staff B flushed the toilet and changed gloves without hand hygiene. H. The staff returned to the resident to complete catheter insertion site care. The staff removed a soaked split sponge with the right hand. I. Staff B obtained disposable wipes from the package with the left hand and cleaned the area with the right hand. J. The staff obtained the split sponge package from the resident's bedside table, opened it, and placed it around the catheter tube insertion using both hands. K. Staff obtained the trash, left the room, removed the gown, and disposed of supplies. The staff failed to complete hand hygiene upon entry into the resident’s room, hand hygiene during glove changes, and placed the collection canister on the floor and on the toilet. 3. Resident #30’s MDS Assessment dated 4/23/26 revealed the resident had a BIMS score of 11/15 indicating moderate cognitive impairment. The document coded the resident required total assistance for toileting hygiene and had an indwelling catheter. The Care Plan, revised 4/8/26, identified a problem area related to the resident’s suprapubic catheter (initiated 4/8/26) provided staff interventions of changing the catheter bag as ordered and providing catheter care as per facility policy. A problem area for EBP (revised 4/8/26) contained staff interventions to follow precautions for high contact activities, and ensure appropriate hand hygiene prior to and after cares. Observed on 6/22/26 at 12:02 PM Resident #30’s uncovered catheter bag hanging from a trash can touching the floor. Observed an EBP sign on the resident’s door, personal protective equipment (PPE) outside the door, and covered trash cans. Observed on 6/23/26 at 8:35 AM Resident #30’s catheter bag without a dignity bag, hanging from the trash can, and touching the floor. Continuous observation on 6/24/26 at 7:50 AM of Staff B and Staff C, CNA, completing activities of daily living (ADL) care for Resident #30 revealed the	F0880		

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F0880 SS = D	Continued from page 7 following: A. Staff B and Staff C donned gowns, entered the resident's room, completed hand hygiene and donned gloves. B. Staff B assisted the resident with rolling in bed, while Staff C completed peri care . C. Staff C completed care maintaining a clean hand, and dirty hand for peri care. D. Staff B completed glove change without hand hygiene. E. Staff B and Staff C placed the brief on the resident and Staff B completed care around the catheter insertion site. F. Staff B changed gloves without hand hygiene. G. Staff and Staff C worked together to don the resident’s pants, roll the resident, place a full body lift sling, and transfer the resident from her bed to the recliner. Staff C had placed the catheter on the resident’s lap during the transfer. H. Staff C hooked the resident's catheter drainage bag on the trashcan with the bottom of the bag touching the floor. I. Staff C changed gloves with hygiene. J. Staff B changed the resident's top, while Staff C made the resident's bed and gathered items for removal. K. Staff B and Staff C changed their gloves without hand hygiene, gathered the dirty items and left the room. The staff removed their gowns and completed hand hygiene following disposal of items from the room. Staff B and Staff C failed to complete hand hygiene tasks throughout ADL cares, and placed the catheter bag on the trashcan touching the floor. Continuous observation on 6/24/26 at 10:45 AM of Staff D, Registered Nurse (RN), with Resident #3 revealed the following: A. Staff D placed facial tissues around the resident’s finger as the staff stated the resident had picked a scab from the finger and it was bleeding. B. The staff disposed of the tissues, entered the	F0880		

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F0880 SS = D	Continued from page 8 bathroom, washed her hands and donned gloves to assess the resident's supra pubic catheter insertion. C. Staff D cleaned the area using disposable wipes and placed a split sponge around the insertion site. D. Staff D disposed of the split gauze packaging, gloves and exited the room. Staff D failed to don a gown before providing care to the resident, change gloves prior to applying a clean split gauze, and complete hand hygiene with glove change and exiting the room. On 6/24/26 at 2:13 PM the Director of Nursing (DON) stated she expected staff to complete hand hygiene upon entry and exit from a resident's room, before donning gloves, and when changing gloves and moving from dirty to clean tasks. The DON stated hand sanitizer was acceptable with glove changes unless the hands were visibly soiled then the staff should wash their hands. The DON expected that if a resident had EBP that gloves and gown were to be used for high contact care including transfers and ADLS. The staff stated suprapubic care was considered an ADL care task. The DON stated a catheter bag should have a cover over it and should hang below the level of the bladder. The DON stated the catheter bag should neither hang from a trash can nor touch the floor. On 6/24/26 at 2:40 PM the Administrator stated staff should complete hand hygiene when entering a resident's room and the use of gloves did not replace hand washing. The Administrator stated EBP should be followed when indicated. The facility's Personal Protective Equipment (PPE) Policy, dated 2025, revealed gloves were a form of PPE, hand hygiene should be completed before donning gloves and after removal, and gloves were not a substitute for hand hygiene. The facility's Hand Hygiene Policy, dated 2025, revealed all staff will perform hand hygiene procedures to prevent the spread of infection. The document disclosed hand hygiene, either washing with soap and water or use of alcohol based hand rub, be completed between resident contacts, and before applying and after removing PPE including gloves. The facility's Enhanced Barrier Precautions Policy, dated 2025, disclosed it is an infection control intervention to reduce the transmission of multidrug-resistant organisms that employs gown	F0880		

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F0880 SS = D	Continued from page 9 and gloves use during high contact resident care activities. The document identified high contact resident care activities including hygiene and device care. The U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP signs on Residents' doors revealed providers and staff must wear gloves and gown during high contact resident care activities including dressing, bathing, transferring, hygiene, changing briefs or assisting with toileting, device care and wound care.	F0880		

The New Homestead

Provider Number 165525

Survey 6/22/26- 6/25/26

POC Disclaimer Statement

Preparation and/or execution of this plan of correction does not constitute admission of agreement by this 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 it is required by the provisions of federal and/or state law.

7/15/2026

F0658 Services Provided Meet Professional Standards.

Residents #3, #30 ordered treatments were completed by a licensed nurse and the suprapubic insertion sites reassessed for immediate corrective action with no issues noted.

The Staff Nurse was given disciplinary action and re-education on professional standards-following Physician orders on 6/25/26.

All residents with suprapubic catheters that have the potential to be affected were audited to verify ordered treatments are completed by appropriate licensed staff.

All licensed Nurses will be re-educated on following Physician orders and scope of delegation.

The DON and/or ADON will conduct random resident audits to verify compliance with professional standards. Audits will be completed weekly for 4 weeks, monthly for 3 months, and quarterly thereafter. Findings will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) Committee. If compliance falls below 100%, the audit schedule will restart, and additional staff retraining or disciplinary action may be implemented.

Compliance date 7/20/26

F0880 Infection Prevention and Control

Residents #3, #10, #30 catheters were placed in dignity bags, positioned off the floor and below the level of the bladder and secured off any trash cans. Enhanced barrier precaution signage and PPE were verified in place outside of rooms for those meeting criteria. Staff observed during the survey received immediate re-education. Residents were assessed and no issues noted from deficient practice.

All residents with catheters and all residents requiring Enhanced barrier precautions have the potential to be similarly affected. Audits of those with catheter bags are covered and kept off the floor, positioned below bladder level and PPE are in place for residents meeting criteria. Any deficiencies identified were corrected immediately.

All nursing staff will be re-educated on infection prevention-handwashing, proper use of PPE and protocol for enhanced barrier precautions, proper placement of and use of dignity bags on catheter bags.

A skills fair was conducted on 7/14/26 to re-education staff of infection prevention and control protocol. Education and demonstration provided by each staff member.

The DON and/or ADON will complete random audits of infection prevention and control protocol. Audits will occur weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter. Audit findings will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) Committee. If compliance falls below 100%, the audit frequency will be reset, and further staff re-education and/or disciplinary actions may occur.

Compliance date 7/20/26