STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165465	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaldaya Lifescapes	7511 University Avenue , Cedar Falls, Iowa, 50613

(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 ✓	INITIAL COMMENTS Correction date: July 17, 2026 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaint #3010494-C, conducted July 6, 2026 to July 9, 2026. Complaint # 3010494-C resulted in no deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and the facility's Safe Food Handling policy the facility failed to clean 3 fans in the 2nd floor dining room. The facility reported a census of 97. Findings include:	F0812	F0812- The facility will continue to store, prepare, distribute and serve food in accordance with professional standards. The three fans located in the second-floor dining area were all cleaned on 7/7/26. The housekeeping task list has been updated to include weekly dusting of the fans and the maintenance department preventative maintenance schedule has been updated to include removing the fans for blade cleaning monthly and as needed. The Maintenance Director, Administrator or designee will complete and document weekly inspections of fan cleanliness x 4 weeks, monthly x 3 months, then quarterly x 3. Any identified concerns will be corrected immediately. This will be monitored by the QAPI committee and reviewed quarterly at QAPI meetings to ensure the solutions are permanent. All staff were educated on 7/16/26 re: expectations, cleaning of fans and reporting of any concerns identified.	

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
Crystal Casper RN, BSN, LNHA	Administrator	7/16/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165465	A. BUILDING B. WING	07/09/2026

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F0812 SS = E	Continued from page 1 On 7/7/26 at 11:45 AM an observation of the second-floor dining room revealed the following: a fan on the left side of the dining room faced the ceiling next to the television near two dining room tables. a fan in the right upper corner of the dining room near the ceiling pointed toward multiple tables and contained gray debris (dirt). a fan on the middle right side of the dining room blew air toward the ceiling over two carts with several room trays near the food serving counter and contained gray debris (dirt). On 7/7/26 at 12:50 PM the Dietary Manager (DM) indicated kitchen staff cleaned the kitchen fans but the maintenance department handled the dining area fans. The DM noted she expected clean fans. On 7/8/26 at 2:30 PM the Director of Nursing (DON) indicated she expected staff to clean the fans. On 7/8/26 at 3:33 PM the Administrator indicated she expected clean dining room fans. The Food Handling and Preparation policy reviewed on 10/23/25 didn't include instructions to keep the fans clean.	F0812		
F0880 SS = E	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 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:	F0880	F0880- The facility will continue to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Staff D was educated immediately on 7/8/26 as well as all staff education was completed on 7/16/26 re: infection prevention and control requirements specific to glove usage, hand hygiene and passing water to residents. Random weekly audits will be conducted x 4 weeks, then monthly x 3 months, then quarterly to ensure the solutions are permanent. Audits will be monitored and reviewed quarterly by the QAPI committee.	

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F0880 SS = E	Continued from page 2 §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. §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.	F0880		

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F0880 SS = E	Continued from page 3 §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 observation, staff interview, and facility policy review, the facility failed to maintain proper infection control practices during the distribution of resident drinking water. This affected 5 resident rooms observed during water distribution. The facility reported a census of 97 residents. Findings include: On 7/8/26 at 3:43 PM a continuous observation revealed Staff D, Certified Nurse Aide (CNA), failed to maintain proper infection control and hand hygiene (hand washing) protocols during an afternoon water pass. Staff D donned (put on) clean gloves, entered resident rooms to retrieve water cups, brought them out to the hallway to fill with ice from a portable ice chest, and returned the cups to the rooms. While wearing the same pair of gloves, Staff D knocked on a resident's door, retrieved a dirty water mug, brought it out to the hallway to fill with fresh ice, and delivered the water into the resident's room. Without removing her gloves or performing hand washing, Staff D proceeded to Room 234. She knocked on the door and retrieved a contaminated, dirty water cup from Room 234's resident while wearing the same gloves. Staff D then entered Room 231 to speak with Room 231's resident. She didn't perform hand washing upon room entry and handled Room 231's resident's water cup using the same contaminated gloves. While in the room, Staff D touched Room 231's resident's shoulder and answered questions. She traveled to the kitchenette (small kitchen area), filled the cup with water, and returned it to the room, all while continuing to wear the same pair of gloves. Staff D proceeded to Room 232, knocked on the door, retrieved Room 232's resident's water mug, and filled it with ice from the communal ice chest while wearing the same gloves. Staff D proceeded to Room 226, knocked on the door, and handled Room 226's resident's ice mug while wearing the same gloves. She then handled an additional water mug belonging to Room 228's resident using the same pair of gloves. At 3:53 PM, after 10 minutes of continuous care across five resident rooms, Staff D removed her gloves and performed hand washing at the handwashing sink located at the nurse's station.	F0880		

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F0880 SS = E	Continued from page 4 On 7/8/26 at 1:15 PM Staff B, Nurse Manager, stated staff must perform hand washing before, during, and after resident care, after touching their own face or hair, after touching a dirty surface, and between all glove changes. On 7/8/26 at 3:59 PM Staff E, Licensed Practical Nurse (LPN), stated staff shouldn't wear the same pair of gloves continuously across multiple resident tasks or rooms. On 7/8/26 at 4:05 PM Staff D stated staff required hand washing and glove changes when activities changed. However, Staff D acknowledged she intended to change her gloves only after completing the entire ice water distribution process. On 7/8/26 at 4:08 PM the Director of Nursing (DON) stated the first and second shifts utilize a mobile ice chest to distribute fresh drinking water. The DON stated employees shouldn't wear gloves during water distribution unless a resident is on active transmission-based isolation precautions (infection containment steps). The DON explicitly stated staff must perform hand washing any time they enter or exit a resident's room. The Hand Washing policy dated 12/29/25 instructed all personnel to perform handwashing to clean the hands and prevent the spread of germs. The policy directed employees to perform hand washing at specific times, including between handling individual residents, after touching any dirty area, and immediately after removing gloves, noting gloves don't offer full protection. The Gloves: Putting on and Taking Off policy dated 12/1/25 instructed staff the outside of gloves is considered contaminated and soiled. The policy directed staff to maintain a distinction between clean and soiled areas, specifying clean should only touch clean and soiled should only touch soiled. The policy mandated employees must wash their hands immediately following the removal of gloves.	F0880		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out	F0677		

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F0677 SS = D	Continued from page 5 activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, observation, resident interview, staff interview, and facility policy the facility failed to provide the necessary activities of daily living (ADL) care regarding nail care for a dependent resident. This failure resulted in a resident having a brown substance embedded under multiple fingernails over two days. This affected 1 of 2 residents reviewed for personal hygiene (Resident #11). The facility reported a census of 96 residents. Findings include: Resident #11's Minimum Data Set (MDS) assessment dated 3/31/26 recorded a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment also noted Resident #11 experienced impaired vision (poor eyesight). The Care Plan revised on 7/7/26 identified a focus area for a self-care deficit (incapacity for self-grooming) related to decreased mobility (limited movement). The document established a daily goal for Resident #11 to remain clean and neatly groomed. To achieve this goal, the text directed staff to provide setup assistance for personal hygiene and one-person physical assistance for bathing via a shower chair. The instructions explicitly required staff to provide nail care with every scheduled shower. Previous entries from 1/7/24, updated on 4/21/26, noted Resident #11 experienced impaired vision with an associated self-care deficit, specifying blindness in the right eye. The document recorded Resident #11 had trouble seeing and instructed staff to closely monitor Resident #11 for ongoing visual declines. On 7/7/26 at 9:05 AM Resident #11 stated during an interview she relies on staff to perform nail care because her poor eyesight prevents her from seeing dirty nails. Resident #11 reported staff didn't trim or clean her fingernails during her shower earlier today. On 7/7/26 at 9:05 AM Resident #11 exhibited a dark brown substance under the thumbnail and middle fingernail of her right hand, and under the index, middle, and ring fingernails of her left hand.	F0677	F0677- The facility will continue to provide the services necessary to maintain good nutrition, grooming, and personal and oral hygiene for those residents who are unable to carry out activities of daily living on their own. All residents' nails were audited on 7/8/26 and cleaned and groomed if necessary. Resident #11 nails were assessed, cleaned and groomed if needed upon return from hospital on 7/12/26. All staff have been educated on ADL cares including nail care on 7/16/26. Random audits will be performed addressing grooming needs including nail care weekly x 4 weeks, then monthly x 3 months, then quarterly x 3 to ensure the solutions are permanent. Audits will be monitored and reviewed quarterly by the QAPI committee.	

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F0677 SS = D	Continued from page 6 On 7/7/26 at 3:32 PM Resident #11 continued to display the dark brown substance under the thumbnail and middle fingernail of her right hand, and the index, middle, and ring fingernails of her left hand. On 7/8/26 at 10:35 AM Resident #11 sat upright in her wheelchair in her room. Resident #11's fingernails remained visibly dirty with the dark brown substance. On 7/8/26 at 1:15 PM Staff B, Licensed Practical Nurse (LPN) Nurse Manager, stated residents receive scheduled showers twice a week unless otherwise indicated. Staff B noted staff must clean and trim fingernails with every shower, when visibly dirty, or as needed. Staff B clarified a licensed nurse must perform nail care if a resident is diabetic; otherwise, Certified Nurse Aides (CNAs) provide nail care during bathing or bed days. During the same interview, Staff B stated following a bath or shower, staff must complete a shower sheet documenting whether they completed nail care or determined it didn't equal a current need. Resident #11's Task record directed staff to provide bathing and shower assistance every Tuesday and Friday on the day shift. The documentation specified Resident #11 required one-person physical assistance to transfer to the shower chair. The entries instructed staff to provide nail care and apply lotion to Resident #11's extremities with every shower. A review of the completed facility Shower Sheet dated 7/7/26 for Resident #11 documented staff didn't trim her fingernails, noting they omitted the care because they deemed it unnecessary. The document recorded the nurse maintains responsibility for verifying completion of all grooming needs. Staff C, LPN, signed and verified the document on 7/7/26. The facility policy titled Personal Care Nails: Care of dated 5/13/26 instructed staff to complete fingernail care by pushing back the cuticle, gently removing dirt from under the nails with a file, and using a clipper or nail file to shape the fingernails into a moon shape.	F0677		

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F0725 SS = D	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. 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) Sufficient Staff. §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: Based on clinical record review, observation, resident interview, staff interview, and facility record review, the facility failed to ensure sufficient nursing staff were available to provide care and answer call lights within a 15-minute timeframe. This affected 3 of 3 residents reviewed for sufficient staffing (Residents #49, #65, and #98) in a sample of 1 of 5 resident halls. The facility reported a census of 97 residents. Findings include:	F0725	F0725- The facility will continue to 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. All staff have been educated on providing care and answering call lights timely on 7/16/26. Specific audits and interviews will be conducted with Resident #49, Resident # 65 and Resident #98 to ensure call lights are timely, needs are met and concerns can be identified or corrected immediately. In addition, random call light audits and resident interviews will be conducted weekly x 4 weeks then monthly x 3 months then quarterly x 3 to ensure solutions are permanent. Audits and interviews will be reviewed and monitored quarterly by the QAPI committee.	

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F0725 SS = D	Continued from page 8 1. Resident #98's Minimum Data Set (MDS) assessment dated 6/8/26 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #98's Care Plan revised 7/6/26 identified a focus area for a self-care deficit (inability to care for oneself) related to decreased mobility (limited movement), hypertensive heart disease (high blood pressure heart condition), chronic kidney disease (long-term kidney damage), and heart failure (weakened heart muscle). To manage care dependencies, the Care Plan directed staff to provide the following nursing assistance: Provide physical assistance of one person for bathing via a shower chair. Provide physical assistance of one person for upper body dressing and physical assistance of two persons for lower body dressing. Provide physical assistance of one person utilizing a gait belt and front-wheeled walker (FWW) to complete stand-pivot transfers. Provide physical assistance of one person for bed mobility tasks. Provide physical assistance of one person to complete transfers to and from the toilet, and provide physical assistance of one person for routine toileting checks and incontinence changes. On 7/7/26 at 7:45 AM Resident #98 stated during an interview her call light frequently required longer than 15 minutes for staff to answer. She stated the facility routinely didn't maintain enough staff, noting the morning shift experienced the most significant delays, usually before and after scheduled meal times. 2. Resident #65's Minimum Data Set (MDS) assessment dated 6/20/26 identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #65's Care Plan revised 7/7/26 identified a focus area for a self-care deficit (inability to care for oneself) related to decreased mobility (limited movement) and chronic obstructive pulmonary disease (COPD) (progressive lung disease) weakness.	F0725		

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F0725 SS = D	Continued from page 9 To manage his high physical care needs, the Care Plan directed staff to provide the following nursing assistance: Provide physical assistance of one person for bathing, applying lotion, and trimming fingernails during showers. Provide physical assistance of one person for upper and lower body dressing. Provide physical assistance of one person utilizing a gait belt and front-wheeled walker (FWW) for transfers and ambulation within his room. Provide physical assistance of two staff members for hallway ambulation, with one person directly assisting the resident and a second person following behind with a wheelchair. Provide physical assistance of one person for bed mobility tasks. Provide physical assistance of one person utilizing a gait belt and FWW to complete toilet transfers. On 7/6/26 at 10:53 AM Resident #65 stated during an interview the facility lacked sufficient staff and frequently didn't have enough help. He stated call light response times routinely exceeded 15 minutes, noting these delays occurred most frequently during the day shift. Resident #65 further noted due to staffing shortages, residents waited in the upstairs dining room for up to an hour for their food after staff brought them to the dining area at 11:00 AM, then additionally had to wait for staff to assist them back to their rooms afterward. 3. On 7/8/26 at 1:22 PM an observation revealed Resident #49's active call light for Room 226. A review of the facility's electronic call light master board at the time revealed the call light remained active and staff hadn't answered it since 12:59 PM, resulting in a 23-minute response delay. On 7/8/26 at 2:25 PM the Director of Nursing (DON) stated during an interview the facility policy required staff to answer all call lights within 15 minutes of activation. DON stated staff must prioritize bathroom call lights to prevent resident falls or accidents. She stated the facility doesn't excuse any employee, from direct floor staff to the administrator, from answering active call lights. When asked how	F0725		

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(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
F0725 SS = D	Continued from page 10 leadership monitors call light response, DON stated leadership conducts physical hall rounds, reviews internal audits, and pulls electronic call light data log reports. A review of the facility's electronic call light log report and audits covering 7/1/26 through 7/8/26 for one of the five facility nursing halls revealed 73 individual instances where call light response times didn't meet the 15-minute facility limit. The log report documented these delayed responses included 16 instances for Resident #49, 4 instances for Resident #65, and 3 instances for Resident #98.	F0725		
F0814 SS = D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and facility's Safe Food Handling policy the facility failed to cover the garbage containers when not in use. The facility reported a census of 97. Findings include: On 7/6/26 at 10:40 AM an initial kitchen tour revealed an uncovered trash container next to the 2-compartment sink and an uncovered trash container by the food preparation table. On 7/7/26 at 11:30 AM a follow-up visit of the kitchen revealed an uncovered trash container next to the 2-compartment sink and an uncovered trash container by the food preparation table. On 7/8/26 at 10:15 AM the Dietary Manager (DM) acknowledged the garbage container lacked a lid, indicated she expected the lid to remain on it when not in use, and closed the lid. The Food Handling and Preparation policy reviewed on 10/23/25 lacked instructions on keeping the garbage containers covered.	F0814	F0814- The facility will continue to dispose of garbage and refuse properly. On 7/8/26 All garbage cans located in the kitchen were audited to ensure lids were utilized when garbage cans were not in use, lids were put on or garbage cans removed from use if no lid. The Food Handling and Preparation policy was updated to include instruction that all garbage containers in the kitchen should be covered when not in use. All staff were educated regarding disposal of garbage and refuse properly specific to garbage cans being covered with a lid when not in use on 7/16/26. Random audits will be performed by the dietary manager to ensure garbage cans in the kitchen are covered with a lid when not in use weekly x 4 weeks, monthly x 3 months and then quarterly x 3 to ensure solutions are permanent. Audits will be reviewed and monitored quarterly by the QAPI committee.	