STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165344	A. Building B. Wing	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record reviews, resident, and staff interviews, the facility failed to protect and promote the rights of the resident by not offering personal choices for 1 of 3 residents reviewed (Resident #10) for bathing and provide dignity to the residents. The facility reported a census of 25. Findings include: 1. Resident #10's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #10 required extensive assistance from one person with bathing. The MDS indicated Resident #10 required limited assistance of one person and a walker for ambulation. Resident #10's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, arthritis, anxiety, depression, borderline personality disorder, spinal stenosis, and a stage three pressure ulcer. The Progress Note dated 9/15/22 at 1:36 p.m. indicated that Resident #10 got upset with the staff changing her shower days. Resident #10 voiced concerns that the staff did not care what she wanted. Review of Resident Hygiene Policy revised in August 2021 revealed any changes in the bath/shower schedule will be discussed with the resident prior to the change. During an interview on 9/27/22 at 10:04 a.m. Resident #10 revealed that she learned that her shower schedule changed from a Certified Nursing Assistant (CNA). Resident #10 reported that the facility or administration did not talk to her prior to making the change in her shower schedule. Resident #10 stated that the staff did not take her preferences or choices on when to take her shower into consideration. Resident #10 reported that she asked to talk to the Director of Nursing (DON) about her change in bath schedule. Resident #10 reported that she felt angry that her shower days changed as she had the same shower schedule for four years. Resident #10 stated that she felt like her feelings didn't matter. During an interview on 10/6/22 at 11:00 a.m. Staff H, Regional Nurse Consultant (RNC), acknowledged that the residents are to have choices in their bath schedule as it is their home. The RNC reported that the residents should get a bath when they want a bath. 44475 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 9/29/22 at 11:49 AM observed Staff E, Activity Director/Social Services, walk out of the dining room into the common area by the nurse's station with residents present. Staff E noticed two Certified Nurse Assistants (CNA) standing across the common area in front of the facility entrance. Staff E called out to the CNAs that Mama had to go potty. The Resident Rights and Dignity Management policy dated August 2021 directed that each resident shall be cared for in a manner that promotes quality of life, dignity, respect and individuality. In an interview on 10/10/22 at 4:41 PM, the Regional Nurse Consultant reported that she would expect staff to use language to promote the dignity of residents. 44474 3. Resident #1 ' s MDS assessment dated [DATE] included diagnoses of muscle weakness, cerebral palsy and asthma. The MDS identified a BIMS score of 14, indicating no cognitive impairment. On 8/21/22 at 2:17 p.m., Resident #1 explained that the staff called her sweetie, honey, or [NAME]. Resident #1 reported that she told staff at the facility several times that she wanted to be called only by her name. Resident #1 further revealed that the staff continued to call her sweetie, honey or [NAME] after she told them she did not like it. On 10/6/22 at 10:44 a.m., observed Staff C, CNA, and Staff M, CNA, provide care to Resident #1. During the observation Staff M call Resident #1 honey on three separate occasions. Resident #1 sighed each time after Staff M addressed her as honey. The Resident Rights and Dignity Management policy dated August 2021 instructed the following: 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 3. Staff shall speak respectfully to the residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his room number, diagnosis, or care needs. 4. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed. On 10/13/22 at 10:22 a.m. the Administrator revealed that residents should be addressed as they prefer. The Administrator added that Resident #1 had brought these concerns to the attention of staff before and wants to be addressed by her name.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record reviews, observations, resident, and staff interviews, the facility failed to provide reasonable care for the protection of the resident's property for 1 of 1 resident reviewed (Resident #10) for inadequate storage of an electric wheelchair. The facility failed to provide a safe, clean, comfortable environment for 1 of 1 resident (Resident #9) for pest control. The facility failed to have housekeeping staff available to deep clean the facility. Due to the lack of housekeepers, the facility had a strong urine smell and dirty carpet. The facility reported a census of 25. Findings include: 1.Resident #10's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #10 required extensive assistance of one person with bed mobility, transfers and toilet use. The MDS indicated Resident #10 required limited assistance of one person and a walker for ambulation. The MDS indicated Resident #10 required a wheelchair for locomotion. Resident #10's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, arthritis, anxiety, depression, borderline personality disorder, spinal stenosis, and a stage three pressure ulcer. During an interview on 9/27/22 at 10:04 a.m. Resident #10 reported that the facility stored her electric wheelchair outside in inclement weather for a couple weeks last fall/winter. Resident #10 reported that she could see the electric wheelchair outside from her window in her room. Resident #10 stated that her dad bought her the electric wheelchair in 2019. Resident #10 reported that she has not used the electric wheelchair for a period of time due to safety concerns. Resident #10 reported that the electric wheelchair is now being stored in the Assisted Living building. Resident #10 reported that her mom took a picture of the electric wheelchair last week. During an interview on 9/27/22 at 11:00 a.m. Staff I, Maintenance Director, reported that the facility stored Resident #10's electric wheelchair in the Assisted Living. He reported that he did not know how long it had been stored there. On 9/27/22 at 11:00 a.m. observed an electric wheelchair in the Assisted Living building. The electric wheelchair had no identification on it. The electric wheelchair did not have a battery and was not operational. The electric wheelchair appeared dirty with dust, bird droppings, the color of the upholstery leather appeared faded and had multiple pinpoint holes in the leather on the seat and back of the chair. During an interview on 9/27/22 at 1:30 p.m. the Administrator and Staff I, the Administrator reported that she did not know the history of the electric wheelchair and did not know if the electric wheelchair in Assisted Living belonged to Resident #10. The Administrator reported Resident #10's mom (POA) inquired about the electric wheelchair last week. Staff I verified that it appeared the electric wheelchair in Assisted Living had sat outside due to the condition the wheelchair is in. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Hospice Progress Note dated 6/19/19 indicated that Resident #10 needed to be reassessed for the use of her electric wheelchair due to safety concerns and weight limit. The clinical record lacked an inventory record. During an interview on 9/28/22 at 9:00 a.m. Resident #10 verified (by pictures the surveyor took) that the electric wheelchair in Assisted Living belonged to her. 2. Resident #9's Minimum Data Set (MDS) dated [DATE] assessment identified a BIMS score of 15, indicating intact cognition. The MDS identified Resident #9 as independent with bed mobility, transfers, toileting and ambulation in the corridor using a walker. The MDS identified Resident #9 with no indicators of psychosis or behavioral symptoms. Resident #9's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, anxiety, depression, post traumatic stress disorder, conversion disorder with motor symptom, and adjustment disorder. The MDS documented Resident #9's admitted as11/20/20. During an interview on 9/28/22 at 9:00 a.m. Resident #9 reported a spider web with a spider on the ceiling in the corner of her room. Resident #9 reported that she told the Dietary Manager and a Nurse about the spider but nothing had been done about it. An observation on 9/28/22 at 9:00 a.m. verified a spider web with a spider and debris in Resident #9's room. During an interview on 9/28/22 at 11:30 a.m. the Administrator reported that the pest management company came to the facility for pest control once per month and more often if needed. On 9/28/22 at 12:42 p.m. the Administrator reported via email that the facility addressed the spider and spider web in Resident #9's room During an interview on 9/29/22 at 9:30 a.m. Resident #9 reported that her room is not cleaned consistently. Resident #9 stated that the Maintenance Director cleaned the bathroom and mopped the floor in her room last week but prior to that, her room had not been cleaned for several months. The facility did not provide a Pest Control Policy and Procedure. 44474 3. On 9/21/22 at 11:04 a.m. the entrance to the building noted a strong odor of urine. The carpets showed visibly dirty and stained by the front door and throughout the living room area. The carpet had various sizes of debris laying on it in the living room area and down the three hallways. On 9/26/22 at 8:17 p.m. upon entering the front door of the building noted large bags tied shut sitting on the floor by the nurses station. The area had an odor of urine and dirty stained carpets. Noted many places in each hallway that had missing and unraveled pieces of carpet. On 9/27/22 at 3:37 p.m., observed the light fixture in Resident #1's filled with dark colored debris. The observation revealed outlines of bugs with wings in the light fixture. Resident #1 explained that she hated looking up at the light in her room because of all of the bugs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/5/22 at 11:03 a.m. the entrance had a strong odor of urine upon entering the front door of the building. The carpet throughout the building appeared dirty and stained. On 10/6/22 at 8:57 a.m. noted an odor of urine in the living room area, no source of the smell located. The smell increased around the living room chairs with a large washable incontinent pad in the seat of the recliners. The carpet appeared visibly soiled, yet, the source of the smell could not be determined. On 9/21/22 at 3:42 p.m. the Maintenance Director revealed that the facility at the time did not have any housekeeping staff. He added that the facility is doing what they could to keep it from looking filthy but no deep cleaning has been done. The facility is currently trying to fill the housekeeping positions. The Resident Rights and Dignity Management policy dated August 2021 directed that residents be provided a safe, clean, comfortable, and homelike environment. On 10/13/21 at 10:17 a.m. the Administrator explained that she expected the staff to clean the residents' rooms when they needed it. She added that the facility was looking for a new housekeeper and everyone has been pitching in when they can to keep the facility clean.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on observations, facility policy review, resident, and staff interviews the facility failed to protect residents' personal belongings and follow up on resident's grievances for 1 out of 3 residents reviewed (Resident #1). The facility reported a census of 25. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of muscle weakness, cerebral palsy, and asthma. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. On 9/21/22 at 2:17 p.m., Resident #1 revealed that she told the staff about a missing pair of earrings. Resident #1 did not know if the staff reported her concern but she knew that she never got offered a replacement item. Resident #1 added that she filled out several grievances with the facility but did not know what ever happened with them. The Grievance Binder lacked documentation of Resident #1's missing earrings. The undated Grievance Policy instructed that the forms should be completed by staff when someone expresses a verbal concern or complaint. The form will serve to document the concern and will be reviewed by the Committee to determine patterns or trends. The completed forms should be directed to the facility's department heads or Administrator. The appropriate Department head should review the concerns and respond as to the resolution of the concerns in writing. The forms are returned to the Administrator and then forwarded to the QAPI Committee for review. On 10/6/22 at 10:02 a.m. the Administrator revealed a grievance should be reported from the resident or staff member to the social worker. From there it goes to the Administrator, who is to do the investigation, resolution, and sign them. The Administrator reported that she did not do that on several reported grievances. The Administrator explained that she had a new Social Services Director and the facility worked with her to make the process complete.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record reviews, observations, facility policy reviews, resident, and staff interviews, the facility failed to prevent 1 of 1 resident reviewed (Resident #3) from inappropriate sexual contact of female residents living the facility. This failure resulted in Immediate Jeopardy to the health, safety, and security of the residents. The facility identified a census of 25 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of bipolar disorder, stroke, traumatic brain injury, and aphasia. The MDS identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The undated Admission Packet included a handwritten note that revealed Resident #3 had sexually inappropriate behaviors. The Preadmission Screening and Record Review (PASRR) level 2 dated 8/17/22 indicated that Resident #3 often struggled to express himself appropriately and had times fixated on sexual themes. The hospital prior to his admission to the facility reported that Resident #3 struggled to express himself appropriately. As he made sexual comments to them and tried to touch them inappropriately. Resident #3's Care Plan Focus revised 8/18/22 indicated that he had inappropriate sexually aggressive behaviors towards other residents and staff. The Care Plan included the following Interventions: a. 6/3/22: Sexual aggression towards another resident. Immediately removed and separated the residents. Resident #3 had a Psych consult with a medication review and received new orders related to his behaviors. b. 8/18/22: Facility Self-Report to the Iowa Department of Inspections and Appeals completed due to inappropriate behaviors towards a female resident. The staff immediately separated the residents and started one to one (1:1) visual supervision. Resident #3 saw the psychiatrist via telehealth that morning and noted that he had not taken his psychiatric medications to help with his mood and libido. The provider changed his Depakote to a liquid to help with administration. The order said that it could be added to juice or chocolate milk. The Provider explained that Prozac may be opened and put in applesauce. The facility faxed a request for Occupational Therapy (OT) evaluation and treatment as indicated for therapeutic activity ideas. 1:1 provided while Resident #3 remained awake until implementation of his medications changes. c. Continued behavior log monitoring. Redirect, re-approach, and have another staff member approach as needed (PRN). Resident #3's Progress Notes review a. 3/14/22 - (Date of Admission) Does ask for inappropriate stuff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. 3/17/22 at 5:44 AM - Resident made several comments last night to the nursing staff about smoking marijuana. He laughs and requests to smoke marijuana. He then made an inappropriate comment to the nurse about jumping into the bed with him and going out for night on the town. c. 3/27/22 at 4:40 AM - The nurse assisted him with his morning cares due to him being awake and wanting to get up. He remained cooperative with cleaning and care. The nurse redirected his on his inappropriate sexual comments, as he asked the nurse if he could touch her tits. The nurse explained that his comments were not appropriate or desired. He then apologized. d. 4/3/22 at 12:25 a.m. - He had sexually inappropriate behaviors that evening. He asked the female staff for sexual favors and when told him that they are not allowed to perform those acts, he calls the staff a string of foul names. He continued to attempt to touch staff in their private areas, reaching for the female staff's breasts while in his wheelchair. e. 4/3/22 at 10:30 p.m. - He Attempted to grab the Certified Nurse Aides (CNAs) when they attempted to provide him care. He asked for sexual favors, then yells and swears at the staff. After he continued to self-transfer, the staff explained that they are trying to help him, he then became sexually aggressive with the staff. f. 4/7/22 at 11:30 PM - Resident #3 continued to be verbally sexually inappropriate to the female staff. He asked the female staff if he could feel their tits. The nurse and staff redirect him that it is inappropriate and that he cannot touch them. He laughed at the staff when they redirected him on his behavior. g. 4/9/22 at 11:28 a.m., -The physician spoke to him regarding his verbal and physical sexual behaviors towards the female staff. He laughed at times and then stated that yeah he understood. h. 4/9/22 at 11:33 a.m. - He continued to ask the female staff to touch their boobs. The staff redirected him saying that his behavior is not appropriate. He laughs and then says ok. i. 5/11/22 at 5:17 PM - He continued to have foul language and make sexual remarks to the staff. j. 5/15/22-Lays in his bed with his incontinence underwear pulled down below his buttocks uncovered facing the door. When a staff member walked by his room he grabbed his penis and pats it with other hand. Then he talks inappropriately to staff about what the staff could do to him sexually. Even after being educated about this behavior he continued to do it. k. 5/25/22 at 8:09 PM - He became aggressive at times by grabbing at the staff, often times in a sexual way. l. 6/3/22 at 12:45 p.m. - The nurse witnessed him touching the left breast of a female resident. The nurse removed Resident #3 immediately from the space and situation. The facility reported the incident as sexual abuse and notified the police. The nurse notified the female residents' family, who decided not to press charges. m. 6/3/22 at 2:37 p.m., The Psychiatry provider changed Resident #3 medications. Orders given for Cimetidine to calm his sexual aggression and increase his fluoxetine from 20 milligrams (mg) to 40 mg daily. The facility initiated 15 minute checks. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	n. 6/7/22 at 12:10 AM - He attempted to touch a female resident, but the staff moved him to his room for the protection of the other residents' protection. o. 8/18/22 at 1:12 PM - The facility completed a self-report for inappropriate sexual behaviors towards a female resident. Staff immediately separated and started 1:1 visual supervision with Resident #3.Resident #3 saw the psychiatry provider via telehealth that morning. Staff reported that he has not been taking his psychiatric medications to help with his mood and libido. The provider changed his Depakote to liquid to help with administration. The order said that it could be added to juice or chocolate milk. The Provider explained that Prozac may be opened and put in applesauce. 1:1 provided while Resident #3 remained awake until implementation of his medications changes. p. 8/19/22 at 1:20 AM -. Resident #3 became very threatening that evening. He took a swing at one of the aides but missed. He tried to grab another aide in between her legs and missed. Then he tried to grab an older lady by the breast. Threatened the nurse that he planned to pull all of her hair out and beat her because he was the boss. q. 8/23/22 at 2:31 AM - Resident #3 continued to be inappropriate around females, he attempted to grab the staff's breast or put his hand between their legs. When the staff informed him that it was not acceptable he just laughed and moved on to another female. He then asked the staff to perform sexual acts on him during routine incontinence care. Resident #3 pulled his incontinence underwear down under his buttocks and laid in bed with his bare buttocks sticking out from the bed. r. 8/25/22 at 12:36 AM - The staff had to remove his hands from two female residents' chairs, as the resident laughed. s. 8/29/22 at 1:09 AM - Resident #3 attempted to go into other residents' rooms and threatened the staff with a balled up fist. t. 9/5/22 at 3:32 AM - Resident #3 continued to be sexually inappropriate with the female staff. Resident #3 laid in bed with his male genitalia exposed yelling out his door to the staff as they walked by his room to come in to do sexual things to or with him. The staff educated him on that his behavior was not acceptable behavior. u. 9/15/22 at 2:07 AM - Resident #3 continued to be sexually inappropriate with the staff and residents. v. 9/25/22 at - While the staff changed his incontinence brief, Resident #3 asked the staff to give him a hand job. The staff finished changing him and left the room. w. 9/26/22- Resident #3 made sexual comments, the staff redirected and reeducated him that it was not appropriate behavior. x. 9/28/22- Resident #3 had inappropriate sexual behaviors towards the female staff. Resident #3 pulled his call light and when the female CNA answered his call light he laid in bed masturbating. He yelled for the CNA to come closer and watch him. When the staff told him that it was not appropriate behavior, he laughed. y. 9/29/22 - Resident #3 exhibited impulsive behaviors related to sex and got easily agitated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	z. 10/5/22 - Resident #3 called the staff names and showed his fist to the staff when they told him his behavior was inappropriate. Resident #3 went to his room and self-transferred into bed at 7:15 PM. Resident #3 had his pants pulled down to his knees with his penis showing while he laid in bed. He made no effort to cover himself when the staff asked him to cover up. He just laughed and told staff to f*** off. aa. 10/6/22 - Resident #3 continued to ask for sexual favors. bb. 10/7/22 - Resident #3 stood up once in the living room to pull up his pants, as his pants were down behind his knees. cc. 10/10/22 - Resident #3 continued to ask the staff to provide sexual acts to him. The staff informed him this was not proper behavior but he just laughed. Physician Progress Notes review: a. 6/3/22 at 2:50 p.m. The staff reported that he is verbally and physically aggressive, irritable and sexually inappropriate. He touched a female resident's breast that day and a staff member's breast the day before. Resident #3 cursed during the exam and acted sexually inappropriate. He admitted to touching a female resident's breast stating that he could help her. Resident #3 became verbally and physically aggressive towards the staff while being sexually inappropriate in his speech and actions. b. 6/9/22 at 12:06 p.m. The physician observed Resident #3 in a follow up and appeared agitated, blocking the residents in the hallway, laughing and attempting to touch the staff inappropriately. c. 9/30/22 at 9:30 a.m. Resident #3 had a follow-up appointment. The staff reported that he had been verbally inappropriate, wandered into the other female's rooms and cursed at staff. The staff did 1:1 with him while he was awake and they did 15-minute checks when he remained in his room. He said, They are elderly women, and he just tried to keep them happy. He reported that he had a problem caressing women before. The staff reported that he continued to make sexually inappropriate comments to the females and exhibited irritability. d. 10/6/22 at 10:00 a.m. The provider last saw Resident #3 on 9/30/22 and renewed his medications without changes. On that day he saw the provider for a follow-up. The staff reported that his behaviors remain unchanged. He exhibited aggression towards the staff, became easily agitated, and continued to be sexually inappropriate. The staff reported that he continued to make sexually inappropriate comments to females. Review of facility provided documentation titled Documentation for Every 15 Minute Checks revealed the following: a. 10/5/22 - lacked documentation of Resident #3 being monitored from 8:15 p.m. until 9:00 p.m. b. 10/6/22 - lacked documentation of Resident #3 being monitored from 10:15 p.m. until 5:45 a.m. c. 10/6/22- lacked documentation of Resident #3 being monitored from 2:00 p.m. until 9:45 p.m. (continued on next page)

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	165344	A. Building B. Wing	10/20/2022

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Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/21/22 at 2:17 p.m., Resident #1 reported that Resident #3 was highly sexual. She revealed that if he could get to you he would. Resident #3 told Resident #1 that she needed an all over body massage without any clothes on. Resident #1 explained that Resident #3 touched her shoulder and attempted to move his hand toward her breast area. Resident #1 revealed that she got away from him right away. Resident #1 reported that Resident #3 always touched the staff and cursed at them. On 9/22/22 at 10:57 a.m., Resident #10 revealed that she felt uncomfortable around Resident #3. Resident #10 is concerned that Resident #3 would come into her room when she is in there and she would not be able to get away from him. Resident #10 saw Resident #3 reach out to touch their breast area and groin area. Resident #10 saw Resident #3 with a cupped hand going up to a female resident walking and looking as if he was going to touch her buttocks. Resident #10 does not like to go to the dining room as Resident #3 causes issues there and she likes to stay in her room to avoid the issues. On 9/22/22 at 11:34 a.m. Resident #9 reported that being uncomfortable around Resident #3. Resident #9 would avoid him or walk around him to avoid having him attempt to touch her in an inappropriate place on her body. Resident #9 reported that Resident #3 stared at her and it made her feel uncomfortable. Resident #9 will put something up to hide her face from him. Resident #9 and her roommate shut their door at night for privacy and so that Resident #3 won't come into their room. Resident #9 explained that Resident #3 has touched many of the staff and female residents. Resident #9 added that it happens so much it is hard to remember everyone that Resident #3 has touched. The undated Behavior Charting policy revealed the following: a. The facility's clinical staff chart behaviors by exception. Meaning if a resident demonstrates a behavior out of their normal character. b. Defined as: Charting by exception (CBE) is a method of medical notation in which nurses only provide notes if there are deviations from a patient's norm or baseline. c. Should a behavior out of the resident's baseline be witnessed or reported the nurse will document it in the resident's chart under progress notes. The Freedom of Abuse, Neglect and Exploitation Abuse Prevention: Fast Alerts policy dated January 2022 revealed the following information: a. The purpose of this written Freedom of Abuse, Neglect, Exploitation; Abuse Prevention Standard is to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment, neglect of residents, and the misappropriation of resident property. The policy instructed to review practices and omissions which if allowed to go unchecked, could lead to abuse. This standard demonstrates a Zero Tolerance of Abuse of any type or manner and will be addressed accordingly. b. The scope of this program shall apply to the prevention of an abuse committed by anyone including but not limited to: staff, residents, consultants, volunteers, family members, staff of other agencies serving the resident, the resident representatives, friends/visitors and other individuals. c. Inappropriate sexual behaviors can include but are not limited to a resident willfully touching another resident/staff on private areas and the resident making sexual statements to others. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. It is the policy of the facility to take all steps reasonable and necessary to protect the residents from harm at all times, including protection from any type of abuse listed from other residents. 1. If a resident-to-resident altercation occurs, staff should intervene immediately. Separate the residents and take them to areas away from each other until the situation has diffused. 1:1 supervision may be needed if resident behaviors are harmful or considered inappropriate. It is imperative to keep residents safe by separation or other interventions needed while investigation is in progress. 2. If staff and appropriate medications, as ordered by the physician, cannot control residents, it may be necessary to call the local police for assistance. 3. If the resident(s) has been injured, provide immediate first aid. If necessary, pursue physician's orders and send the resident to the hospital. 4. If the resident(s) is cognitively alert, counsel the resident on proper behavior. Assessment of a BIMS score and capacity to consent should be reviewed for cognitive status. 5. Notify the Director of Nursing and the Administrator immediately. Notify the physician, family, and/or guardian. Notify the Regional Nurse Consultant for guidance. If the resident-to-resident altercation involves inappropriate sexual behaviors, then the Allegation of Abuse for Inappropriate Sexual Behaviors should be implemented immediately. 6. Complete all necessary documentation for reporting the incident. Ensure that if 1:1 supervision for the resident(s) is indicated that the action gets documented. 7. The investigation protocol must be implemented, and a report given to the appropriate agencies as specified by law and regulations. 8. All incidents are to be documented in the resident's medical record with monitoring to continue for at least 72-hours. The resident's Care Plan and Kardex should be updated to reflect immediate interventions and long-term interventions to reduce the risk of reoccurrence of the behavior and to protect resident safety. 9. If residents are roommates and cannot get along, notify their family/guardian of the need for a room change. Temporarily separating the residents until this process can be completed may be necessary to avoid further altercations. 1:1 supervision may be needed. 10. If the physician and facility feel that a resident will be a danger to the other residents and/or self; the facility will seek proper placement at another facility. In the meantime, residents will be monitored for safety. 11. If a resident is found to be on the Sex Offender Registry, each resident's status will be considered individually to determine if the resident's needs can be met by the facility and if other residents can be maintained in a safe environment. A. The facility will identify, correct and intervene in identified at-risk situations in which abuse, neglect and/or misappropriation of resident property are more likely to occur. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	i. The distribution of staff on each shift in sufficient numbers to meet the needs of the residents and assure that staff assigned has knowledge of individual care needs. ii. The supervisor of staff will identify inappropriate behavior such as the use of derogatory language, rough handling, or ignoring residents during care. B. The facility will identify and investigate suspicion of or allegations of abuse of residents. They will review the occurrence and identify patterns and trends that may constitute abuse. That information will be used to determine the direction of the investigation. The results of the investigation will be reviewed by the facility's Quality Assurance/Performance Improvement Committee and entered into the minutes. 3. Employee, resident, responsible party training regarding: abuse identification, reporting, prevention, screening, investigation, and protection. Training will occur upon hire and annually thereafter unless performance indicates additional training is needed. On 10/13/22 at 10:32 a.m. the Administrator reported that the documentation should have been filled out every shift and there should be no blank areas and the staff is to be with him now 1:1. The facility is still currently working on a more appropriate placement for him and until then he is being monitored by the facility. The State Agency informed the facility of the Immediate Jeopardy (IJ) on September 22, 2022 at 2:34 p.m. The facility removed the IJ on September 28, 2022 through the following actions: a. 1:1 care of the resident when awake and 15 minute checks on Resident #3 while he is sleeping. b. 1:1 staff scheduling c. Staff education on appropriate care for Resident #3 d. Documentation on Resident #3 during 1:1 supervision and 15 minute checks e. Psychiatric provider medication review f. Resident #3 educated on appropriate behavior around others The State Agency informed the facility that the IJ continued on October 11, 2022 at 11:11 a.m. The facility removed the IJ on October 13, 2022 through the following actions: a. 1:1 supervision with Resident #3 b. Reeducation of the staff c. Psychiatric provider medication review (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. Exploring options for better placement for Resident #3 e. Resident #3 reeducated on appropriate behavior around others The scope lowered from K to E at the time of the survey after ensuring the facility implemented education with their policy and procedure.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 44474 Based on personnel file reviews, staff interviews, and facility policy review, the facility failed to ensure all employees had an Iowa Criminal Background check, dependent adult, and child abuse registry check (SING) completed within 30 days of hire date for 1 out of 5 employees reviewed (Staff L). The facility reported a census of 25 residents. Findings include: The personnel file for Staff L, Director of Business Management, indicated a start date of 6/30/22. The facility completed a SING on 5/21/22. The facility did not run another background check prior to Staff L ' s start date. The SING got completed more than 30 days before Staff L ' s start date. The policy titled Freedom of Abuse, Neglect & Exploitation; Abuse Prevention dated August 2021 revealed the facility background screens are submitted after a conditional offer is extended to an employee and must be received within the appropriate time frames per state requirements. On 9/28/22 at 4:07 p.m. the Administrator stated she would expect the facility to have another background check done prior to the hire date since 30 days had passed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record reviews, facility policy review, and staff interviews, the facility failed to develop a Care Plan for resident following their admission to the facility after with fall prevention interventions for 1 of 13 residents reviewed (Resident #17). The facility reported a census of 25 residents. Findings include: Resident #17's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. The MDS included a diagnosis of non-Alzheimer's dementia. The MDS indicated that Resident #17 required extensive assistance with transfers and toileting. Resident #17 had two falls without injury and two falls with injury (not major) since his admission or reentry or prior assessment, whichever is more recent. The Admission Summary Note dated 5/10/22 at 4:44 PM indicated that Resident #17 admitted to the nursing home due to a history of a recent hospitalization and failed discharge to home with home health. Resident #17's goals for admission are to increase conditioning, reduce falls, and improve swallowing. Resident #17's Clinical Record revealed he had a fall on 5/11/22, 5/23/22, 6/15/22, 6/17/22, 6/18/22, 6/20/22, and 6/22/22. The undated Care Plan Focus identified that Resident #17 had a risk of falls. The interventions directed the staff to evaluate fall risk on admission and as needed (PRN). The undated Care Plan focus identified Resident #17 with a high risk for falls related to gait problems, balance problems, and poor comprehension. The interventions included the following: 1. Post fall 5/11/22. Ensure frequent rounding and high alert in the evening. 2. Post fall 5/23/22: Orthostatic blood pressures and medication review related to sleep pattern. 3. Second Post fall 5/23/22, Resident #17 had minor bruising and skin tears to his arms. Staff received education to lock his brakes before leaving him. Resident #17 had a physician visit and received new orders for labs, electrocardiogram (EKG), and a chest x-ray (CXR). Staff initiated a room change for Resident #17. 4. 6/15/22 Post fall. Educate and ensure Resident #17 used his front wheeled walker (FWW) with transfers as he will allow. The primary care provider PCP to evaluate his edema (swelling) to his bilateral (both) lower legs. 5. Post fall 6/17/22: mirtazapine increased. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Post fall 6/18/22: assist him into a wheelchair to allow him independent mobility in a supervised area. Psych consult requested. 7. First post fall 6/20/22 - anti-roll back brakes ordered for Resident #17's wheelchair. Staff to evaluate Resident #17's weight loss and notify the Dietitian. 8. Second post fall 6/20/22 - The PCP visited Resident #17 and gave new orders of a Hospice consult. 9. Post fall 6/22/22: Minor injury with laceration to right eyebrow, the nurse applied pressure to the site. Resident #17 went to the emergency room (ER) for evaluation. The Care Plan lacked interventions prior to Resident #17's first fall at the facility. The RAI/Care Planning Management policy with a revision date of 7/22 revealed the following: 1. Care plans are to be updated in an acute situation when identified, such as falls, falls with injury, new skin alterations, worsening skin conditions, behaviors, resident events, weight loss, infections, uncontrolled pain, allegations of abuse and other concerns that involve resident care/condition. These updates are to be prompt upon notification and should be reviewed and implemented in the daily clinical meeting and as they occur. 2. It is the practice of this facility to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. a. To identify the resident's individual needs and care requirements. b. To assure that an interdisciplinary team assesses the emotional, psychosocial, mental, and physical needs of each resident. On 10/10/22 at 4:45 PM, the Regional Nurse Consultant reported that she would expect a Care Plan to contain interventions after each fall occurred to prevent future falls and then additional interventions due to the number of falls he had.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record reviews, observations, resident, and staff interviews, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 1 residents reviewed (Resident #10) for treatment administration. 1. Resident #10 had an order for Ready Wraps to help control her swelling in her lower legs. Throughout the survey observations revealed Resident #10 either not wearing her Ready Wraps all day or not until later in the afternoon. 2. In addition, the facility failed to keep resident's personal information secure. The facility reported a census of 25. Findings include: Resident #10's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #10 required extensive assistance of one person with bed mobility, transfers and toilet use. The MDS indicated Resident #10 required limited assistance of one person and a walker for ambulation. The MDS indicated Resident #10 required a wheelchair for locomotion. A balance during transitions and walking identified Resident #10 as not steady and only able to stabilize with staff assistance with the following: moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfers. Resident #10's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, arthritis, anxiety, depression, borderline personality disorder, spinal stenosis, and a stage three pressure ulcer. The MDS documented Resident #10's admitted as 2/8/18. The Care Plan revised on 9/6/22 identified that Resident #10 took a diuretic medication related to edema and a diagnosis of hypertension (high blood pressure). The Care Plan identified that Resident #10 utilizes lymphedema wraps per physician orders. The Care Plan recorded that Resident #10 declined wraps at times and requested early removal at times. The Care Plan directed the staff to educate Resident #10 related to the risk involved, redirect, and reapproach. A Physician Order updated 9/12/22 directs staff to apply Ready Wraps to bilateral lower extremities (BLE) every morning and to remove the Ready Wraps at hour of sleep (HS). Review of Resident #10's electronic treatment record (ETAR) in September 2022 lacked documentation of the removal of Ready Wraps at HS. On 9/26/22 at 1:00 p.m. observed Resident #10 sitting in her wheelchair in the front lobby without Ready Wraps on her bilateral (both) lower legs. Resident #10 had gripper socks on. Resident #10's bilateral legs appeared edematous and discolored. On 9/27/22 at 9:20 a.m. observed Resident #10 sitting in a wheelchair in front of the nurses station without Ready Wraps to her bilateral lower extremities. On 9/28/22 at 8:30 a.m. observed Resident #10 sitting up in her wheelchair in her room. Resident #10 did not have Ready wraps not in place to her bilateral lower extremities. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/28/22 at 11:35 a.m. observed Resident #10 outside smoking without wearing her Ready Wraps on her legs. 0n 9/28/22 at 1:30 p.m. observed Resident #10 leave for a wound center appointment in her wheelchair without Ready Wraps in place to bilateral lower extremities. Noted the Ready Wraps in Resident #10's room and hanging over her walker. On 9/28/22 at 4:00 p.m. observed Resident #10 in the hallway with the Activity Director. She did not wear her Ready Wraps on her bilateral lower extremities. On 10/4/22 at 10:54 a.m. observed Resident #10's wound treatment with Staff D, LPN (Licensed Practical Nurse). During the wound care, Resident #10 reported her Ready Wraps were in the laundry since the previous afternoon. Staff D reported that she planned to check on the Ready Wraps that morning and had got busy. On 10/4/22 at 1:50 p.m. observed Resident #10 in her room without her Ready Wraps on her bilateral lower extremities. During an interview on 9/26/22 at 1:05 p.m. Staff D, reported that she did not have time to put Resident #10's Ready Wraps on. The electronic Treatment Administration Record (ETAR) included a timestamp that showed the application of her Ready Wraps occurred at 2:22 p.m. During an interview on 9/27/22 at 10:04 a.m. Resident #10 reported that the previous day her Ready Wraps did not get put on until late because of the nurse being so busy. Resident #10 reported that there are days the Ready Wraps did not get put on until 5 p.m. During an interview on 10/3/22 at 2:54 p.m. Staff F, RN (Registered Nurse), reported they applied the Ready Wraps in the morning and removed them at night. Staff F reported occasions when her Ready Wraps did not get put on. Staff F reported that it is usually related to her shower getting delayed. During an interview on 10/4/22 at 9:09 a.m. Staff G, RN/MDS Coordinator, acknowledged that she would expect Ready Wraps to be applied in the morning according to the physician order. 44475 2. On 9/26/22 at approximately 9:30 PM witnessed two plastic bags sitting on a medication cart with a pharmacy label of the resident's name. During the observation, noted one medication bubble pack and one insulin pen on the top of the nurse's station visible to the common area with prescription labels on each medication that contained the resident's name. The Resident's Rights and Dignity Management policy dated 8/21 directed that staff shall maintain an environment in which confidential clinical information is protected. On 10/10/22 at 04:54 PM, the RNC reported that she expected prescription labels that have the resident's name listed would be kept in a confidential location.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record reviews, resident interviews, staff interviews, and facility record review the facility failed to provide a bath twice weekly and/or per a resident's preference for 1 of 3 residents reviewed for bathing (Resident #1). The facility reported a census of 25 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of cerebral palsy, chronic pain, and muscle weakness. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. Resident #1 required total dependence on two persons for bathing assistance. On 9/21/22 at 2:17 p.m. Resident #1 reported that she did not get her baths twice a week as scheduled. Resident #1 added that she went over a week without a bath. Resident #1 described that she felt dirty and that she smelled. The Care Plan Intervention revised 9/4/22 directed that Resident #1 required staff to bathe her and she preferred to only have bed baths. The Bath Schedule Sheet documented Resident #1's bath days as Mondays and Thursdays. Resident #1's May 2022 Bath Record a. lacked documentation that she had a bath on i. scheduled days: 5/12, 5/19, and 5/26. b. Unschedule day marked as not applicable (NA) i. 5/28 Resident #1's June 2022 a. lacked documentation that she had a bath on i. 6/2, 6/9, 6/16, 6/23, and 6/30 b. included documentation of NA ii. 6/6, 6/20, and 6/27 Resident #1's July 2022 included documentation of NA on 7/7. Resident #1's August 2022 included documentation of NA on 8/25, and 8/29. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's September 2022 included documentation of NA on 9/22. The Resident Hygiene policy dated August 2021 indicated that it is the standard to bathe each resident daily, to include a sponge and/or bed bath five times weekly (or more often, if needed) including a tub bath, whirlpool bath, or shower at least twice weekly. Tub and whirlpool baths or showers are scheduled for each resident and are given at various times of the day, modified according to the resident's condition, preferences, and desires, whenever possible. On 10/13/22 at 10:19 a.m. the MDS nurse revealed that the staff should not be marking NA on any documentation and should mark if they refuse a bath. All residents should be offered a bath twice a week but they do have the right to refuse.

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Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record reviews, observations, resident, staff, and physician interviews the facility failed to assure that a resident with a pressure ulcer received treatment and services, consistent with professional standards of practice, to promote healing of a stage three pressure ulcer for 1 of 1 resident reviewed (Resident #10). The facility reported a census of 25. Finding include: The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, with slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue) which may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound. Other staging consideration include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent skin. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #10's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #10 required extensive assistance of one person with bed mobility, transfers and toilet use. The MDS indicated Resident #10 required limited assistance of one person and a walker for ambulation. The MDS identified Resident #10 as always continent of bowel and bladder. The MDS identified Resident #10 at risk for developing pressure ulcer and indicated that she had an unhealed stage three pressure ulcer during the seven day lookback period. The MDS also identified the facility had placed a pressure reducing device in the resident's chair, provided pressure ulcer care, applications of medication and dressing to her feet, in addition the facility added nutrition and hydration interventions Resident #10's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, arthritis, anxiety, depression, borderline personality disorder, spinal stenosis, and a stage three pressure ulcer. Resident's 10's Care Plan revised 9/6/22 contained the following information: a. Resident #10 could not transfer independently due to diagnoses of spinal stenosis, diabetes mellitus, and chronic pain. The Care Plan directed that Resident #10 required assistance of one person with transferring and ambulation using a platform walker. Resident #10 used a wheelchair for longer distances. b. Resident #10 is at risk for skin breakdown related to skin impaired mobility and chronic kidney disease. The care plan directed staff to: - Encourage and assist to reposition frequently - Monitor meal intake and monthly weight - Observe skin and any wound changes such as redness, tenderness, foul drainage, heat. Notify the medical Doctor (MD). - Pressure reducing mattress to her bed and a cushion in her chair - Skin checks per facility protocol - Resident #10 took diuretic medication related to edema and diagnosis of hypertension. Monitor for signs and symptoms of dehydration. Utilizes lymphedema wraps per physician order. Declines wraps at times and requests early removal at times. Educate Resident #10 the related risk involved, redirect, and reapproach. - Treatments as ordered. Treatments continue to the right plantar foot pressure area. Wound center appointments continue. Resident #10's Care Plan lacked information regarding interventions of offloading to decrease or prevent pressure to her right plantar foot, the nutrition, and/or hydration intervention to promote healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Braden Scale assessments (tool used to evaluate risk of development of a pressure ulcer) documented a score of 10-12 indicated that the resident had a high risk for pressure sore development, 13-14 meant the resident had a moderate risk, and 15-18 meant the resident had a risk for pressure ulcer development. The review of the Braden Scale assessments completed for Resident #10 from 11/21 to 7/22 documented scores on the following dates: 1. 11/2/21= 19 2. 4/25/22=17 3. 7/20/22=16 Resident #10's clinical records lacked a Braden Scale assessment in the first quarter of 2022. The Skin Management Standard policy and procedure with a revised date of August 2021 instructed that all residents will be assessed using the Braden Skin assessment tool on admission, readmission, quarterly, and with a change of condition. Residents with a score of 8 or greater will be considered at risk for skin breakdown. An Incident Reported (IR) dated 6/5/22 at 4:42 a.m. identified Resident #10 developed a 7 centimeter (cm) large blood filled blister on her right heel. The IR documented the surrounding tissue as edematous, red in color, blanchable, and very tender to touch. According to the IR, Resident #10's right foot rested on the back of her foot pedal. Nursing removed the foot pedal for safety and applied skin prep to the blister. The IR stated there were no predisposing environmental, physiological or situation factors. Resident 10's wound evaluation forms revealed the following information: -7/20/22: Stage 3 pressure ulcer to right plantar foot that measured (Length x Width x Depth) 1.3 cm x 0.8 cm x 0.1 cm. Wound bed with granulation. Wound with purulent drainage. Peri wound maceration. No odor, tunneling or undermining present -7/25/22: Stage 3 pressure ulcer. 1.5 cm x 0.8 cm x 0.1 cm. Wound bed with granulation. No drainage. Peri wound with maceration. No odor, tunneling, or undermining present. -8/22: Stage 3 pressure ulcer. 1.4 cm x 0.7 cm x 0.1 cm. Wound bed with granulation. No drainage. Peri wound maceration. No odor, tunneling or undermining present. -8/8/22: Stage 3 pressure ulcer. 1.4 cm x 0.7 cm x 0.1 cm. Wound bed with granulation. No drainage. Peri wound maceration. No odor, tunneling, or undermining present. -8/15/22: Stage 3 pressure ulcer. 1.2 cm x 0.5 cm x 0.1 cm. Wound bed with granulation. No drainage. Peri wound maceration. No odor, tunneling, or undermining present. -9/29/22: Stage 3 pressure ulcer. 0.7 cm x 0.4 cm x 0.2 cm. Wound bed with slough. No drainage. Peri wound skin normal. No odor, tunneling, or undermining present. The clinical record lacked wound evaluations/assessment completed for the following weeks: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- June 12th - June 19th - June 26th - July 3rd - July 10th - August 22nd - August 29th - September 5th - September 12th - September 19th - September 26th The Skin Management Standard policy and procedure with a revised date of August 2021 states the wound(s) will be measured and assessed for size (length, width, depth, undermining, drainage, odor, debris, such as slough or eschar), utilizing the Push (Pressure Ulcer Scale for Healing) Tool, with the findings documented in the resident's record every week. The wound will be assessed at least weekly by a licensed nurse and the Director of Nursing (DON) will participate in the weekly wound rounds. During an interview on 9/28/22 at 1:30 p.m. with Staff G, RN (Registered Nurse), and the MDS Coordinator reported that the expectation for skin assessments is to complete them weekly in the electronic medical record. During an interview on 9/28/22 at 1:40 p.m. the Administrator reported that all skin evaluations are completed in the electronic medical record. She did not know of any further documentation. Review of Resident #10's wound center notes from the Wound Healing Center revealed the following information: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An initial evaluation on 6/15/22 documented Resident #10 had a stage 3 wound with etiologies of a pressure ulcer and a diabetic ulcer of the lower extremity. The wound is located on the right plantar foot. The wound measured 6 cm length x 12 cm width and 0.1 cm depth. The fat (subcutaneous) layer was exposed. There was no tunneling or undermining noted. There was a medium amount of serosanguineous drainage noted. The wound margin was thickened. There was a large (67-100%) amount of red granulation within the wound bed. There was a small (1-33%) amount of necrotic tissue within the wound bed including eschar and adherent slough. The wound required excisional debridement. The Provider documented Resident #10 may shower without the wound dressing and to wash with soap and water. The Provider directed Resident #10 to wear Ready Wraps and elevate legs to the level of the heart or above for 30 minutes daily and/or when sitting. Provider directed off-loading and to apply foam heel lift boots at all times when not up walking. Provider directed the following treatment to the right plantar wound, cleanse with soap and water, apply Bactroban topically one time per day, apply Mepilex foam 4x4 and apply conforming stretch gauze bandage. Wound Center appointment on 6/29/22 documented Resident #10 had a stage 3 pressure ulcer to the right plantar foot. The wound measured 1.5 cm length x 1 cm width x 0.1 cm depth. There was a small amount of necrotic tissue within the wound bed including adherent slough. The wound required excisional debridement. The Provider directed staff to continue antibiotic cream and Mepilex border along with offloading. The Provider ordered formal lymphedema therapy as Resident #10 had significant edema to lower legs and her right lower leg was very red and congested. Resident #10 reported to the Provider that her Ready Wraps are not applied to her lower legs consistently. Wound Center appointment on 7/20/22 documented Resident #10 had stage 3 pressure ulcer to the right plantar foot. The wound measured 1 cm length x 0.4 cm width x 0.1 cm depth. There was a small amount of serosanguineous drainage. There was a small amount of necrotic tissue within the wound bed including adherent slough. The wound required excisional debridement. No changes made to the treatment plan in regards to ulcer. The Provider stated Resident #10 should be seen formally by lymphedema. Wound Center appointment on 8/10/22 documented Resident #10 had a stage 3 pressure ulcer that was slowly improving but macerated. The wound measured 0.7 cm length x 0.3 cm width x 0.1 cm depth. There was a small amount of red, pink granulation within the wound bed. There was a medium (34-66%) amount of necrotic tissue within the wound bed including adherent slough. The wound required excisional debridement. Provider reported Resident #10 lower leg swelling is under better control with minimal redness but does not feel it is completely optimized. The Provider ordered to continue with the current treatment plan but only apply a small amount of antibiotic cream given maceration. The Provider documented that she would prefer lymphedema wraps to Ready Wraps and to continue offloading the right foot as much as possible. Wound center appointment on 8/24/22 documented stage 3 pressure ulcer on the right plantar foot measured 0.7 cm length x 0.2 cm width x 0.1 cm depth. There was a small amount of necrotic tissue including eschar and adherent slough. The wound required excisional debridement. The Provider documented that the ulcer made slow improvement but had built up a callus again. The Provider stated the leg swelling and redness had significantly improved since last assessment. The Provider documented no changes to the current treatment plan and to continue offloading as much as possible. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound Center appointment on 9/7/22 documented stage 3 pressure ulcer on the right plantar foot measured 0.7 cm length x 0.2 cm width x 0.1 cm depth. There was a medium amount of necrotic tissue. The wound required excisional debridement. The Provider documented the ulcer is extremely macerated but slowly improving. Resident #10 reported to the Provider that the facility had not been changing her dressing consistently and leaving the dressing on with showers. The Provider ordered to change treatment to Aquacel Ag with Mepilex to help with the maceration. The Provider directed pressure relief, whether this is sheepskin on her pedal or putting a pillow between her pedal and foot, the wound may be delayed in healing due to pressure on the pedal. The order directed the facility to continue with foam heel lift boots all times when not up walking. The clinical record review revealed a physician order dated 6/15/22 for the foam heel lift boots to bilateral lower feet at all times, unless walking. The facility failed to implement the order on the electronic treatment administration records (ETAR) until 9/11/2022 at 2:07 p.m. On 9/26/22 at 1:00 p.m. observed Resident #10 sitting in her wheelchair in the front lobby, not wearing her foam heel lift boots on her feet. She only had on socks. On 9/27/22 at 9:20 a.m. observed Resident #10 sitting in a wheelchair in front of the nurses' station. Resident #10 did not wear foam heel boots to her bilateral lower extremities. On 9/27/22 at 12:54 p.m. observed Resident #10 in a wheelchair in the front lobby with no foam heel lift boots on her feet. On 9/28/22 at 8:30 a.m. observed Resident #10 sitting up in her wheelchair in her room with a cloth heel protector on her right foot and gripper socks on her left foot. On 9/29/22 at 9:07 a.m. observed Resident #10 without foam heel lift boots. Resident #10 wore only gripper socks to her bilateral feet. During an interview on 9/27/22 at 10:04 a.m. with Resident #10 reported that she only had one boot that she wore on her right foot. She did not wear or have a boot for her left foot. She reported that her right boot got wet on either Friday or Saturday so they sent it to the laundry to get cleaned and it had not come back. During an interview on 10/6/22 at 11:00 a.m. Staff H, Regional Nurse Consultant (RNC), reported that she would expect the foam heel lift boots to be on the ETAR for documentation and for the staff to apply the boots as the physician order directed. The Clinical Record revealed the facility dietician on 6/21/22 recommended Resident #10 to start Arginaid twice a day to promote wound healing due to the pressure ulcer to the right foot. The physician order to start the Arginaid was received on 6/30/22. According to the ETAR, the Arginaid did not get administered on the following dates: July 28th, 29th, 30th, August 13th, 15th, 16th, 17th, 18th, 20th, 22nd, 23rd, September 14th, 15th, 16th and 17th. The review of Progress Notes indicated that the facility did not have an Arginaid packet available on the following days: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 7/30/22 at 7:24 a.m. - 7/30/22 at 8:08 p.m. - 8/17/22 at 9:07 a.m. - 8/18/22 at 8:23 a.m. - 8/22/22 at 8:48 p.m. - 8/23/22 at 10:09 a.m. - 9/14/22 at 10:28 a.m. - 9/15/22 at 9:22 a.m. During an interview on 10/6/22 at 11:00 a.m. Staff H, Regional Nurse Consultant (RNC) reported that she would expect the facility to have the supplies on hand. The Clinical Record revealed that the facility received a Physician order from the wound center on 6/15/22 for a treatment to the right plantar pressure wound. The order stated to cleanse the pressure wound with soap and water, apply Bactroban topically one time per day, apply Mepilex foam 4 x 4 and apply conforming stretch gauze bandage. The facility on 6/16/22 at 10:02 a.m. placed an order on the ETAR to apply Bacitracin ointment 500 Unit/gram (GM) topically every day. The facility failed to transcribe the correct order to the ETAR as ordered by the Provider. The facility discontinued the Bactroban order on 9/7/22. The June 2022 ETAR lacked documentation of the completion of the wound treatment on 6/30/22. The July 2022 ETAR lacked documentation of the completion of the wound treatment on the following dates: 7/4, 7/7, 7/26 and 7/28. The August 2022 ETAR lacked documentation of the completion of the wound treatment on the following dates: 8/3, 8/5, 8/9, 8/18, 8/19, 8/20, 8/21, 8/28, 8/30. The September 2022 ETAR lacked documentation of completion of the wound treatment on the following dates: 9/1 and 9/2. The Medication Administration Policy dated August 2021 directed the staff to compare the MAR (Medication Administration Record) with the label of each medication for the following: right person, right medication, right date, right time, right route, right dose and expiration date. If there is a discrepancy, the medication will not be administered. Instruction will be verified by contacting the physician or pharmacy. During an interview on 10/4/22 at 1:10 p.m. the facility's pharmacist verified the pharmacy received the order of Bactroban from the wound center in June and sent it to the facility. The pharmacist reported they did not have any record of a physician order for bacitracin. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/4/22 at 3:20 p.m. the Wound Center Provider explained that if Resident #10's dressing changes did not get done consistently then it could affect the wound. The Provider reported the wound bed as being macerated (breakdown due to being wet) in appearance, as if something sat on the wound for a period of time. The Provider said that if the dressing changes did not get done then that could be the cause of the maceration. The Provider stated Resident #10 reported of occasions when the dressing changes did not get done. The Provider explained that the wound is small enough that it should be healed by now but it is hard to say what is preventing or delaying the healing process. The Provider stated that she prefers Bactroban over the bacitracin ointment as it provides more coverage. The Provider stated if the facility used bacitracin it probably did not delay the wound healing. During an interview on 10/6/22 at 11:00 a.m. Staff H, Regional Nurse Consultant (RNC), reported that she expected Physician orders to be transcribed and completed as directed by the Physician. The Clinical Record Review revealed the facility received an order for lymphedema therapy from the wound center provider on 6/29/22. The facility's Occupational Therapist (OT) completed the evaluation and plan of treatment on 7/21/22. The physician signed the Plan of Care on 7/22/22. The OT Certification period for therapy services was from 7/21/22 to 9/18/22 and for three times a week. The facility OT discontinued therapy services on 8/19/22 per the facility's discretion. The OT evaluation on 7/21/22 indicated the following lymphedema therapy goals: - STG (Short Term Goal): Decrease edema by 10 cm in bilateral lower extremities. - LTG (Long Term Goal): Decrease edema by 20 cm in bilateral lower extremities. The Discharge Summary on 8/19/22 indicated Resident #10 met the following goals - STG LLE (Left Lower Extremity) decreased 10 cm - on 8/15/22. The Discharge Summary on 8/19/22 indicated Resident #10 did not meet the following goals: - STG RLE (Right Lower Extremity) decreased 8.3 cm. - indicating progression towards the goal. - LTG LLE Decreased Edema 15.1 cm - indicating progression towards the goal. - LTG RLE Decreased Edema 8.3 cm - indicating progression towards the goal. The Occupational Discharge Summary signed and dated on 8/23/22 documented that Resident #10 discharged from Occupational Services on 8/19/22 due to the plan for Resident #10 to receive lymphedema care through the hospital and wound clinic. The OT recommendations included Ready Wraps for lymphedema, continue to increase sage functional mobility into daily activities (including transfers and ambulation), and promotion of activities of daily (ADLs) with the least restrictive assistance. The Clinical Record recorded that Resident #10 had not started services at the Lymphedema Clinic since the discontinuation of OT services at the facility on 8/19/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/27/22 at 4:00 p.m. the Administrator reported the Lymphedema Clinic called on 8/24/22 informing them of a 4-6 week wait time to schedule an appointment for Resident #10. During an interview on 9/28/22 at 10:45 a.m. Staff J, Occupational Therapist (OT), reported that they discharged Resident #10 from lymphedema therapy. Staff J reported that the facility decided to end lymphedema therapy at the facility and have Resident #10 receive services through the hospital. Staff J did not know why the facility decided to make the change. Staff J reported that she did not know that the lymphedema services at the hospital had not been started yet due to the 4-6 week wait time. During an Interview on 10/3/22 at 10:15 a.m. the Lymphedema Clinic receptionist confirmed they received Resident #10's lymphedema therapy order. The receptionist reported the waiting list had Resident #10 on it to be seen and they would call the facility to schedule the appointment when available. During an Interview on 10/4/22 at 11:30 a.m. the Administrator reported that Resident #10 had a lymphedema center appointment scheduled for 10/5/22. The Administrator reported that she did not know why therapy discontinued Resident #10's lymphedema therapy in August and called the Director of the therapy department to get more information. During an interview on 10/4/22 at 3:20 p.m. the Wound Center Provider explained if Resident #10 did not use the Ready Wraps consistently, her legs are going to be a big problem in the future and she will likely develop further skin issues. During interview on 10/5/22 at 11:30 a.m. the Administrator and Staff H, RNC, reported Staff K, OT/Director of Therapy, reported that they discontinued Resident #10's lymphedema due to Staff K not being able to be in the building three times a week to complete the lymphedema therapy. The RNC reported the facility made the decision to discontinue therapy and transition services to the hospital. The Administrator reported that Staff K is the only therapist on staff trained in lymphedema. During an interview on 10/5/22 at 11:40 a.m. Staff K reported that she is the only person trained to do lymphedema therapy. She reported that she could not get to the facility three days a week. Staff K reported that she lived in [NAME] and had 13 facilities that she traveled to. Staff K stated that she did not know that the hospital's Lymphedema Therapy had a waiting list. Staff K reported that if she knew that she would have made her schedule work and would not have discontinued Resident #10 from caseload. Staff K reported that the facility did not communicate regarding the wait time for the appointment. Staff K explained that Resident #10 wore Ready Wraps daily so the lost progress should be able to be regained pretty quickly.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record reviews, resident, and staff interviews, the facility failed to provide a restorative program to a resident with mobility for 2 of 3 residents reviewed (Resident #1 and #10) and failed to provide oral hygiene for 1 of 3 resident reviewed (Resident #10). The facility reported a census of 25. Findings include: 1. Resident #10's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #10 required extensive assistance of one person with bed mobility, transfers, personal hygiene and toilet use. The MDS indicated Resident #10 required limited assistance of one person and a walker for ambulation. The MDS indicated Resident #10 required a wheelchair for locomotion. A balance during transitions and walking identified Resident #10 as not steady only able to stabilize with staff assistance with the following: moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfers. Resident #10's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, arthritis, anxiety, depression, borderline personality disorder, spinal stenosis, and a stage three pressure ulcer. The Care Plan revised 9/6/22 instructed the staff to transfer Resident #10 with the use of a platform walker and assist of one. The care plan documented that Resident #10 ambulated short distances with a walker and assistance of one. Resident #10 used a wheelchair for longer distances. The Care Plan directed that Resident #10 required set up assistance with oral care. During an interview on 9/28/22 at 9:00 a.m. Resident #10 reported that she used a platform walker with the assistance of one person to ambulate to the bathroom. Resident #10 reported an Occupational Therapist walked her the last time she walked in the hallway when she received therapy. During an interview on 9/29/22 at 9:07 a.m. Resident #10 stated that she would like to have a routine walking program. Resident #10 reported that she couldn't get to the bathroom to brush her teeth. She reported that the staff had to bring items to her in her wheelchair so she could brush her teeth. Resident #10 reported that her wheelchair could not go through the bathroom door. Resident #10 reported that she did not get her teeth brushed consistently. Resident #10 reported she had not had her teeth brushed that week. Resident #10's Clinical Record lacked a current physician orders for walking or a restorative maintenance program to assist with ambulation or ADL care (oral hygiene) to maintain and achieve the highest level of well being. The Clinical Record review revealed Resident #10 received Occupational Services from 7/21/22 to 8/19/22 due to edema and weakness. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Occupational Evaluation signed and dated 7/22/22 documented that Resident #10 could not participate in ADLs due to the loss of sensation in her lower extremities and low activity tolerance. Resident #10 required movement of fluid in her lower extremities as well as interventions to increase mobility, functional transfers, and ambulation. The Occupational Discharge Summary signed and dated on 8/23/22 recorded that Resident #10 discharged from Occupational Services on 8/19/22 with the following recommendations to continue safe functional mobility into daily activities (including transfers and ambulation), and promotion of ADLS with the least restrictive assistance. The Therapist documented that no Restorative or Functional Maintenance Program indicated at that time. Review of Restorative Policy with a revision date of August 2021 directed that a Restorative Nursing Process is an effort to help the resident do more for themselves and to become a more independent person. The policy indicated that restorative care is a dynamic process which aids a resident in achieving optimum physical, emotional, psychological, and social well being. The purpose is to deliver quality restorative care that meets the needs of each resident and assists each resident in reaching the highest level of practicable level of physical, mental, and psychosocial functioning. The policy stated that the resident would be assessed for the need for Restorative Nursing Programs on admission and periodically thereafter or as condition changes. During an interview on 9/28/22 at 10:45 a.m. Staff J, Occupational Therapist (OT), reported that Resident #10 did not get discharged with a restorative program due to being able to request walks with the staff as she wanted them. Staff J stated that the facility did not have the staff to oversee a restorative program. Staff J reported that she could order a walking program but if they did not have the staff to do it then it wouldn't get done. On 9/28/22 at 12:42 p.m. the Administrator replied via email that the facility did not have a restorative program but the aides did assist the residents with restorative activities as they could. During an interview on 10/6/22 at 11:00 a.m. Staff H, Regional Nurse Consultant (RNC), reported that the facility did not have a formal restorative program. The RNC reported that she is in the process of developing a restorative program that could be assigned to residents that would benefit from the programming. The RNC reported that the staff could take residents for a walk when they requested it. Nursing can also direct the Certified Nursing Assistants on which residents to take for a walk. 44474 2. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of muscle weakness, cerebral palsy, and asthma. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. On 9/21/22 at 2:17 p.m. Resident #1 revealed that she did not get any type of therapy. Resident #1 reported that the facility told her that she used all her days but she did not know what that meant. Resident #1 expressed that she wanted to have therapy as she gets stiff and sore all over. Resident #1 revealed she felt that it would help her to be able to stretch out her muscles. On 10/13/22 at 10:07 a.m. the Administrator confirmed that the facility did not have anyone doing restorative therapy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on observations, facility policy, and staff interviews, the facility failed to provide adequate incontinence care for a resident to prevent an infection for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 25 residents. Findings include: Resident #2's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS included diagnoses of chronic obstructive pulmonary disease (COPD, causes shortness of breath during activity and rest), bipolar schizoaffective disorder, and delusional disorder. The MDS indicated that Resident #2 required extensive assistance of two persons with transfers and toilet use. The MDS identified Resident #2 as frequently incontinent of urine and bowel. On 10/4/22 at 12:06 PM observed Staff A, Certified Nurse Assistant (CNA), clean Resident #2's perineum. After leaving Resident #2's perineum the wipe contained bowel movement (BM or poop). Staff A continued to use the same wipe, to clean Resident #2's perineum again. The Perineal Care Standard policy dated August 2021 directed the staff to use one personal wipe for each cleansing motion. On 10/10/22 at 4:48 PM, the Regional Nurse Consultant reported that she would expect the staff to use a new wipe to clean a resident and not one that contained BM.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 44475 Based on clinical record reviews and staff interviews, the facility failed to provide residents with an in person face-to-face physician visit for 3 of 5 residents reviewed (Residents #15, #22, and #23). Each resident saw their provider via telehealth. The facility reported a census of 25 residents. Findings include: The Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Reference: Quality Service QSO-22-15-NH dated 4/7/22 discontinued the waiver that allowed physicians and non-physicians to conduct telehealth visits instead of in-person visits effective 5/7/22. 1. Resident #15's Telemed Note dated 8/8/22 indicated that he had a telehealth physician visit. 2. Resident #22's Telemed Note dated 9/4/22 indicated that she had a telehealth physician visit. 3. Resident #23's Telemed Note dated 8/2/22 indicated that he had a telehealth physician visit. Resident #23's Telemed Note dated 10/6/22 indicated that he had a telehealth physician visit. Each residents' clinical review lacked documentation of an onsite visit completed in the previous 60 days. In an electronic mail (email) dated 10/20/22 at 12:32 PM, the Regional Nurse Consultant (RNC) reported the physician determines the timing and location of their visit. We do not have a policy stating this. On 10/20/22 at 3:56 PM, the RNC reported that the contracted Medical Director company's contract will be expiring because the company is not able to provide face-to-face physician visits.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record reviews, facility record reviews, resident, and staff interviews the facility failed to provide sufficient staff to meet the needs of the residents who resided in the facility for four of 15 residents reviewed (Resident #1, #16, #9, and #10). Residents reported that the staff could not answer their call light within 15 minutes due to the lack of staff. The facility reported a census of 25 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of muscle weakness, cerebral palsy, and asthma. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. On 9/21/22 at 2:17 p.m. Resident #1 reported that the staff took up to an hour to answer her call light. Resident #1 expressed concern that she is unable to get up when she asks to get out of bed since she required two persons to help her. She remarked that sometimes the facility did not have enough staff to get her up and she has to stay lying in bed all day or until another shift comes on duty with enough staff. 2. Resident #16's MDS assessment dated [DATE] included diagnoses of cerebral Palsy, muscle weakness and osteoarthritis. The MDS identified a BIMS score of 15, indicating no cognitive impairment. On 9/21/22 at 3:17 p.m. Resident #16 explained that the facility only had one Certified Nursing Assistant (CNA) on the floor with one nurse. Resident #16 reported that she had to wait a long time after she put on her call light to get help for herself or her roommate. Resident #16 explained that the Director of Nursing (DON) worked on the floor a lot as a CNA. 46875 3. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS listed that Resident #10 required extensive assistance of one person with bed mobility, transfers, and toilet use. The MDS indicated that Resident #10 required limited assistance of one person and a walker for ambulation. The MDS indicated Resident #10 required a wheelchair for locomotion. A balance during transitions and walking identified Resident #10 as not steady only able to stabilize with staff assistance with the following: moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfers. Resident #10's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, arthritis, anxiety, depression, borderline personality disorder, spinal stenosis, and a stage three pressure ulcer. During an interview on 9/27/22 at 10:04 a.m. Resident #10 reported that the staff could take up to 15 minutes or more to answer her call light at times. Resident #10 reported that she would push the call light, watch the clock, and if over 15 minutes she would write it down. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS identified Resident #9 as independent with bed mobility, transfers, toilet use, and ambulation in the corridor using a walker. The MDS identified Resident #9 with no indicators of psychosis or behavioral symptoms. Resident #9's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, anxiety, depression, post traumatic stress disorder, conversion disorder with motor symptoms, and adjustment disorder. During an interview on 9/29/22 at 9:30 a.m. Resident #9 reported that the staff could take 15-20 minutes to answer her call light. Resident #9 reported that she watches the clock on the wall and writes it in her notebook. During an interview on 10/6/22 at 11:00 a.m. Staff H, Regional Nurse Consultant (RNC), reported that she would like the staff to answer the call lights within two minutes but strives for five minutes. The RNC reported that she is looking into a new, updated call light system for the facility to help monitor the call light times more efficiently.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44474 Based on facility staff records and staff interviews, the facility failed to assure a staff member was properly trained to work as a Temporary Nursing Assistant (TNA) for one of five staff members (Staff N) reviewed for sufficient staffing. In addition, the facility failed to ensure someone other than the newly hired employee reviewed the employment physical form to determine if the staff could work safely at the facility for one of five employees reviewed (Staff D). The facility reported a census of 25 residents. Findings include: Staff N's, Business Office Manager, employee file included a TNA certificate dated 10/15/21. Staff N's file lacked documentation regarding her competency to perform the duties of a certified nursing assistant. On 9/28/22 at 10:17 a.m. Staff N revealed that she did not have any competency training. On 9/28/22 at 3:14 p.m. the Administrator reported that Staff N did not have a competency checklist completed. The Administrator confirmed that she expected that one should have been done. 44475 2. The Facility's form Pre-Employment/Post Offer and Annual Physical for Staff D, Licensed Practical Nurse (LPN) documented completed by Staff D on 7/5/22. The form lacked vital signs and a signature by someone other than the newly hired employee. Staff D indicated that she had a medical condition that could cause harm to a resident or other staff member. The section labeled if yes, please explain lacked further documentation. On the bottom of the Staff D's Pre-Employment/Post off and Annual Physical form dated 7/5/22 directed the following: a. All new hires must have a drug test and a physical. b. Iowa physicals must be signed by the Director of Nursing (DON) or Regional Nurse Consultant (RNC) and completed every 4 years. On 10/11/22 at 11:07 AM, the Administrator reported that they had no additional information other than the employee information she supplied. The Administrator indicated that the electronic mail (email) contained everything the facility had, if the email did not have it, the facility did not have the document.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44474 Based on review of the facility's schedule and staff interview, the facility failed to ensure a registered nurse (RN) on duty for 8 hours each day for 7 days per week, including weekends and holidays. The facility reported a census of 25 residents. Findings include: The Facility's Nursing Staff Schedule reviewed from 5/1/22 through 9/1/22 revealed that the facility did not have an RN on duty for 8 hours on 7/4/22. On 10/5/22 at 1:38 p.m. the Administrator confirmed that the facility did not have any RN work on July 4, 2022. The Administrator added that she had two Licensed Practical Nurses working in the building that day. The Administrator confirmed that there should have been a RN working for 8 hours that day. The State Operations Manual revised 11/22/17 instructed that unless the facility received a waiver, the facility must use the services of a registered nurse for at least 8 consecutive hours a day for 7 days a week.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on record review and staff interview, the facility failed to assure residents were free from significant medication errors for 4 of 4 residents reviewed (Resident #2, #4, #5, and 12). The facility reported a census of 25 residents. Findings Include: 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of anxiety, bipolar disorder, psychotic disorder, Schizophrenia, and respiratory failure. The MDS identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Resident #2 used an antianxiety medication for seven out of seven days in the lookback period. Resident #2's August 2022 Medication Administration Record (MAR) listed the following information: a. Invega Tablet Extended Release 24 Hour 3 milligrams (MG) (Paliperidone ER) start date of 8/5/22. Give 3 MG by mouth in the morning for bipolar type disorder. i. The MAR documented the medication with an indicator of 5 (hold / see Nurses Notes). b. Clonazepam Tablet 1 MG started on 6/2/22. Give one tablet by mouth three times a day related to schizoaffective disorder, bipolar type. ii. The MAR's documentation on 8/26/22 at 1:00 PM indicated that the Resident #2 did not receive her dose due to sleeping. iii. The MAR's documentation for 8/27/22 at 1:00 PM and 5:00 PM indicated that Resident #2 did not receive her doses with the indicator of 5. iv. The MAR's documentation for 8/28/22 and 8/29/22 at 9:00 AM and 1:00 PM in addition to 8/28/22 at 5:00 PM indicated that Resident #2 did not receive her doses with the indicator of 9 (other / see nurses notes). C. Clonazepam Tablet 1 MG started on 8/29/22. Give 1 mg by mouth two times a day for unspecified anxiety disorder and bipolar disorder. i. The MAR's documentation identified a indicator of 9 that Resident #2 did not receive her doses for 8/29/22 and 8/30/22 evening shift, 8/30/22 and 8/31/22 day shift. ii. On 8/31/22 evening shift, the documentation indicated that Resident #2 received her dose. Resident #2's September 2022 MAR included the following information: a. Clonazepam Tablet 1 MG started on 8/29/22. Give 1 mg by mouth two times a day for unspecified anxiety disorder and bipolar disorder. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. The MAR's documentation for 9/1/22 listed the identifier of 9, indicating that Resident #2 did not receive her dose for the morning or evening shift. Resident #2's clinical record lacked documentation related to the reason she did not receive her medication. 2. Resident #4's MDS assessment dated [DATE] included diagnoses of stroke, diabetes mellitus and Coronavirus 2019 (COVID-19). The MDS identified a BIMS score of 10, indicating moderately impaired cognition. Resident #5 received an opioid for seven out of seven days in the lookback period. Resident #4's September 2022 MAR review: a. The following medication lacked documentation to indicate that Resident #4 received his medication for the evening shift of 9/23/22. i. Clopidogrel bisulfate Tablet 75 MG start date of 5/22/22. Give one tablet by mouth one time a day related to transient cerebral ischemic attack, unspecified. ii. Acetaminophen Tablet start date 9/2/22. Give 650 MG by mouth three times a day for Pain related to wedge compression fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing. iii. Gabapentin Capsule 100 MG start date 7/27/22. Give two capsules by mouth three times a day related to low back pain, unspecified. iv. Tramadol HCl Tablet 50 MG start date 9/19/22. Give 50 MG by mouth three times a day for Moderate Pain. 1. Resident #4's clinical record lacked documentation related to the reason why he did not get his medications on 9/23/22. b. Tramadol HCl Tablet 50 MG start date 9/8/22 and discontinued on 9/19/22. Give 50 MG by mouth three times a day for Moderate Pain. i. The MAR lacked documentation of administration for the early doses on 9/9/22 - 9/17/22. 1. The Progress Note dated 9/8/22 at 5:46 PM indicated an order for tramadol HCL tablet 50 MG. Give 50 MG by mouth every six hours as needed for moderate pain. 2. The Progress Note dated 9/9/22 at 8:48 PM documented that Resident #4 had an order for bedtime. 3. The eMar - Medication Administration Note dated 9/10/22 at 8:43 PM recorded that Resident #4 had two different orders, the nurse awaited clarification of the orders. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The Health Status Note 9/11/22 at 9:41 AM indicated that the nurse called Resident #4's hospice provider regarding his current Tramadol started by the hospice provider, as well as previous tramadol orders per his primary care provider (PCP). The nurse needed confirmation to discontinue his previous orders, as they are different from the current orders. The hospice planned to reach out to the nurse to receive the order to discontinue the previous orders and fax the confirmation to the facility when able. 5. The eMar - Medication Administration Note dated 9/11/22 at 8:29 PM indicated that Resident #4 denied the need for tramadol at that time. 6. The Health Status Note dated 9/12/22 at 11:57 AM identified that the hospice nurse came to the facility to discuss the previous tramadol orders and the need for clarification to discontinue. Resident #4 awaited clarification from his hospice provider. 7. The Health Status Note dated 9/12/22 at 1:09 PM indicated that the facility received a fax by Resident #4's PCP to discontinue the previous tramadol orders of every hour of sleep and every eight hours as needed (PRN). 3. Resident #5's MDS assessment dated [DATE] included diagnoses of heart failure, depression, chronic obstructive pulmonary disorder (COPD), and diabetes mellitus. The MDS identified a BIMS score of 13, indicating no cognitive impairment. Resident #5's September 2022 MAR revealed the following information: a. Breo Ellipta Aerosol Powder Breath Activated 100-25 micrograms (MCG)/inhaled (INH) (Fluticasone Furoate-Vilanterol) start date - 8/10/22 0800, Discontinued date - 9/29/22. Give one puff inhaled orally once a day for chronic obstructive pulmonary disease. - lacked documentation of being administered on 9/2/22, 9/7/22-9/17/22 and 9/19/22. b. Myrbetriq Tablet Extended Release 24 Hour (Mirabegron ER) start date 8/10/22. Give 50 mg by mouth one time a day for overactive bladder. - lacked documentation of being administered on 9/22/22 and 9/23/22. c. Artificial Tears Solution 1% (Carboxymethylcellulose Sodium) start date 8/9/22. Instill one drop in both eyes two times a day for an unspecified cataract. - lacked documentation of being administered on 9/2/22 and 9/722-9/17/22. d. Basaglar KwikPen Solution Pen-injector (Insulin Glargine) 100 UNIT/ milliliters (ML) start date 8/9/22. Inject 46 unit subcutaneously two times a day for type 2 diabetes mellitus with diabetic polyneuropathy. - lacked documentation of being administered on 9/7/22 and 9/17/22. e. Entresto Tablet 49-51 MG (Sacubitril-Valsartan) start date - 8/9/22l; discontinued date 9/14/22. Give one tablet by mouth two times a day for unspecified heart failure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- lacked documentation of being administered on 9/11/22. f. Flovent HFA Aerosol 110 MCG/ACT (Fluticasone Propionate HFA) start date - 8/23/22; discontinued 9/29/22. Give two puffs inhaled orally two times a day related to UNSPECIFIED CHRONIC OBSTRUCTIVE PULMONARY DISEASE. - lacked documentation of being administered on 9/11/22. g. Gabapentin Capsule start date 8/9/22. Give 200 mg by mouth three times a day for Type 2 diabetes mellitus with diabetic polyneuropathy. - lacked documentation of being administered on 9/11/22. h. Norco Tablet 7.5-325 MG (HYDROcodone-Acetaminophen) start date 9/2/22. Give one tablet by mouth three times a day for chronic pain. - lacked documentation of being administered on 9/12/22 and 9/30/22. i. NovoLOG Solution (Insulin Aspart) start date 8/9/22. Inject as per sliding scale: if 70 - 150 = 0; 151 - 200 = 3u; 201 - 250 = 6u; 251 - 300 = 9u; 301 - 350 = 12u; 351 - 400 = 15u; 401 - 450 = 18u; and greater than (>) 450 notify the doctor. Give subcutaneously with meals for Type 2 diabetes mellitus with diabetic polyneuropathy. - lacked documentation of being administered on 9/7/22. j. HYDROcodone-Acetaminophen Tablet 7.5-325 MG start date - 8/9/22; discontinued on 9/2/22. Give one tablet by mouth four times a day for unspecified osteoarthritis, unspecified site. - lacked documentation of administration on 9/1/22-9/2/22. Progress Notes review a. Breo Ellipta Aerosol Powder Breath Activated 100-25 micrograms Lacked progress notes related to the reason that Resident #5 did not receive his medication. b. Myrbetriq Tablet Extended Release 24 Hour (Mirabegron ER) 9/22/22 at 8:31 AM documented the medication as not available. The pharmacy is sending. 9/23/22 at 8:39 AM indicated that Resident #5 did not have the medication available. c. Artificial Tears Solution 1% (Carboxymethylcellulose Sodium) The eMar - Medication Administration Note dated 8/9/22 at 5:51 PM indicated the facility did not have the medication. d. Basaglar KwikPen Solution Pen-injector (continued on next page)

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Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lacked progress notes related to the reason the resident did not receive the medication. e. Entresto Tablet 49-51 MG (Sacubitril-Valsartan) Lacked progress notes related to the reason the resident did not receive the medication. f. Flovent HFA Aerosol 110 MCG/ACT Lacked progress notes related to the reason the resident did not receive the medication. g. Gabapentin Capsule Lacked progress notes related to the reason the resident did not receive the medication. h. Norco Tablet 7.5-325 MG (HYDROcodone-Acetaminophen) The eMar - Medication Administration Note dated 9/12/22 at 11:56 AM documented the facility did not have the medication. 9/30/22 lacked a progress note related to the reason the resident did not receive the medication. i. NovoLOG Solution (Insulin Aspart) lacked a progress note related to the reason the resident did not receive the medication. j. HYDROcodone-Acetaminophen Tablet 7.5-325 MG 9/1/22 documentation indicated the nurse knew that the facility had no medication for Resident #4. 9/2/22 documentation indicated the medication got ordered. The Medication Administration Guidelines dated August 2021 directed the following: a. Document signature or initials as required for medications administered on the MAR immediately following administration or per state standards. b. Review each MAR after each medication administration is completed and prior to the end of the shift to ensure documentation is complete and supports services provided, including, but not limited to, the following: - Documentation of initials on MAR for medications administered during current shift - Identification of omissions or inconsistencies within MAR documentation. Report findings to nursing management at time of discovery and notify MD and responsible party of disruption of care as clinically indicated. - Review circled initials and documentation of the reason why the medication did not get administered, including resident refusals. Clarifying statements in the progress notes may also be needed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Documentation of initials on MAR for PRN medication administration with reason for administration and effectiveness of medication noted on back of MAR On 10/13/22 at 11:01 a.m. the MDS Nurse stated that the medication should not have run out, and if they were out the nurse should have notified the physician. 44475 4. Resident #12's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. The MDS included the diagnosis of type 2 diabetes mellitus with diabetic polyneuropathy. Resident #12 received insulin injections for seven out of seven days in the lookback period. The Order Summary Report signed by a physician on 7/7/22 revealed that the resident was prescribed Humalog to be administered 3 times per day. The Medication Administration Record (MAR) for 2022 revealed the facility failed to administer Humalog within 1 hour or longer after meals as follows: a. 32 times in June b. 17 times in July c. 16 times in Aug The Medication Administration Guidelines Policy dated August 2021 directed that medication could be administered within 60 minutes before or after the prescribed time. On 10/10/22 at 5:04 PM, the Regional Nurse Consultant (RNC) reported that she would expect Humalog to be administered at breakfast, lunch, and dinner.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44475 Based on observations, facility records, resident, and staff interviews, the facility failed to offer residents a menu with a variety of foods and/or offer alternative foods. The facility reported a census of 25 residents. Findings include: On 9/22/22 at 11:35 PM, Staff E, Activity Director/Social Services, reported that she observed that the residents eat the same foods all the time. On 9/29/22 at 9:30 AM, Resident #9 reported that the same foods are served on a two week cycle. On 9/28/22 at 9:00 AM, Resident #10 reported that the facility had options for substitutes but the kitchen needed to know ahead of time, usually by 10:00 AM. Staff did not always update the menu written on the white board in the dining room. The use of the white board worked as the only way for residents to know the daily menus. Resident #10 reported that residents talk about the food issues during Resident Council Meetings but they did not see them get addressed. The Resident Council Meeting Minutes dated 2/15/22 documented that the residents complained that food lacked variety with the same foods served every week. The Menus for the week of 6/29/22 to 7/5/22 revealed that the residents received a bologna sandwich twice, potato chips twice, and mashed potatoes three times. The undated Menu Alternate policy instructed that an alternate meat or entree, an alternate vegetable, and alternate starch should be provided at every meal in the event of personal food preferences or refusals. On 10/6/22 at 10:52 AM, the Dietary Manager (DM) reported that she knew that the residents complained of the lack of variety in the menus. The DM explained that the staff encourage the residents to order alternate foods in the morning but that they could still request an alternative during the meal.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44475 Based on facility records, resident, and staff interviews, the facility failed to serve the food at a safe and palatable temperature. The facility reported a census of 25 residents. Findings include: On 9/28/22 at 9:00 AM, Resident #10 reported that she did not always get her food served hot. On 9/29/22 at 9:30 AM, Resident #9 reported that the kitchen served cold food sometimes. The Resident Council Meeting Minutes dated 2/15/22 and 3/22/22 listed that the residents complained about having cold food. The Food Temperature logs dated April 2022 to August 2022 lacked documented temperatures for a total of 241 meals. The undated Food Temperatures policy directed that the food was to be maintained at a proper temperature to ensure food safety. The temperature must be taken and recorded for all items at all meals. On 10/6/22 at 10:48 AM, the Dietary Manager (DM) reported that she would expect the food temperatures to be taken prior to serving food to the residents.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 44474 Based on facility records and staff interviews the facility failed to maintain accurate records of staff education provided related to a concern with a male resident touching other female residents. The facility reported a census of 25 residents. Findings include: On 9/26/22 at 11:26 p.m. when asked for the staff education, the Administrator presented one original copy of the staff education with three pages of photocopies with white out on six of the dates with the 22nd marked in. On 9/26/22 at 11:42 a.m. questioned about the original staff education paperwork and the dates on the original form that had white out on the copy dated 9/23/22. On 9/26/22 12:41 p.m. the Administrator explained the difference in dates on the paperwork. The Administrator stated Staff N, Business Office Manager (BOM), called the staff and wrote down the wrong date. The Administrator continued that the staff signed the wrong date on the paperwork. The Administrator revealed Staff D, Licensed Practical Nurse (LPN), Staff O, LPN, and Staff I, Maintenance Director, worked in the office on Thursday 9/22/22 but did not sign the paperwork. On 9/26/22 at 12:57 p.m., Staff D, LPN, verified her signature and date on the original paperwork dated 9/23/22. Staff D verified that she did not work on Thursday and was not in the office with the Administrator. On 9/26/22 at 1:36 p.m Staff I, Maintenance Director, confirmed that he attended a meeting on Thursday but the facility called him on Friday 9/23/22 and told him that he needed to sign the education sheet. The staff reported that they wanted it done by 10:00 a.m. Staff I reported that at that time he left the facility with a resident for an appointment. Staff I reported the facility was supposed to write him down as verbal education as he responded to a text. Staff I verified that he did not sign that form. On 9/26/22 at 1:49 p.m Staff P, Dietary, verified she received the education and the education form on Friday 9/23/22. On 9/26/22 at 2:03 p.m. Staff Q, Certified Nursing Assistant (CNA), explained that she got a phone call and a text message from the facility about the education on 9/23/22. Staff Q said the text message came on 9/23/22 at 9:42 a.m. Staff Q added the expectation of the staff to respond back to the message to acknowledge the education. On 9/26/22 at 2:09 p.m. Staff R, Cook, said that on 9/23/22 the Administrator and her supervisor talked to her about the situation. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/26/22 at 2:18 p.m. Staff S, CNA, reported that she received a mass text message from the Administrator on 9/23/22 at 9:45 a.m. The message stated that the staff had to respond to the message by 10:00 a.m. On 9/26/22 at 2:51 p.m. Staff N, BOM, explained that the facility educated the staff in the building on Thursday 9/22/22 but sent the text message out on Friday 9/23/22 to all staff. On 9/27/22 at 10:12 a.m. Staff T, Registered Nurse (RN) stated that the facility put an intervention in place of a one to (1:1) right away but the staff did not get trained until Friday 9/23/22. Staff T further revealed she trained the evening shift, who were to educate the night shift. Then the night shift were to educate the day shift. Staff T revealed the Administrator sent out the education to all staff on Friday 9/23/22. On 9/26/22 at 2:53 p.m. the Administrator confirmed that she made the changes to the dates on the education forms. On 10/19/22 at 12:07 p.m. the Regional Nurse Consultant verified that the dates on the documents should have never been changed.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 44475 Based on facility records, facility policy, and staff interviews, the facility failed to ensure completion of an employee's tuberculosis (TB) test by reading the results to indicate the employee did not have TB before starting to work at the facility for one of five staff reviewed (Staff U). The facility reported a census of 25 residents. Findings include: Staff U's, Certified Nurse Assistant (CNA), Pre Employment and Annual TB Test Results form dated 4/29/22 lacked a TB test result. The Facility Assessment Tool dated 8/18/17 revealed that the facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: 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 and following the accepted national standards. On 10/11/22 at 11:07 AM, the Administrator reported that they had no additional information other than the employee information she supplied. The Administrator indicated that the electronic mail (email) contained everything the facility had, if the email did not have it, the facility did not have the document.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to ensure resident records accurately protrayed the resident with thorough documentation for 2 of fifteen residents reviewed (Resident #13, Resident #11, and Resident #10) for clinical records. 1. The facility failed to document an admission assessment for Resident #13. 2. The facility failed to inventory Resident #11's personal property at admission. 3. The facility failed to maintain or take an inventory of Resident #10's personal property at admission. The facility reported a census of 25 residents. Findings include: 1. Resident #13's Minimum Data Set (MDS) assessment dated [DATE] listed his admitted as 9/7/22. The Clinical Census reviewed on 9/21/22 revealed an admission to the facility on [DATE]. The Brief Interview for Mental Status (BIMS) assessment completed on 9/7/22 indicated a score of 3, indicating severe cognitive impairment. Resident #13's clinical record lacked an Initial or Admission Nursing Assessment. The RAI/Care Planning Management policy dated July 2022 directed that nursing admission assessments are completed during the admission process. On 10/10/22 at 4:58 PM, the Regional Nurse Consultant (RNC) reported that she would expect the nurses to perform an initial assessment at the time of the resident's admission to the facility. 2. Resident #11's MDS dated [DATE] identified a BIMS score of 4, indicating severely impaired cognition. The MDS indicated Resident #11's admitted as 5/20/22. The Clinical Census listed Resident #11's admission as 5/20/22. Resident #11's clinical record lacked an inventory of personal effects. On 9/28/22 at 1:12 PM, the Administrator reported that she recently learned of the issue of residents not having their inventory of personal property obtained on admission to the facility. She explained that they were working on correcting that issue. 46875 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Resident #10's Minimum Data Set (MDS) dated [DATE] assessment identified a BIMS score of 15, indicating intact cognition. Resident #10's MDS included diagnoses of hypertension, renal insufficiency, diabetes mellitus, arthritis, anxiety, depression, borderline personality disorder, spinal stenosis, and a stage three pressure ulcer. The MDS documented Resident #10's admitted as 2/8/18. The Clinical Record for Resident #10 lacked a personal inventory record. The Homelike Environment policy revised August 2021 instructed that residents are provided a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible.The policy continued to state resident possessions will be allowed into the facility as feasible and will be inventoried upon admission and with changes. During an interview on 9/27/22 at 1:30 p.m. the Administrator stated that she did not know if Resident #10 had an inventory record on file. The Administrator stated that she doubted Resident #10 had one as she lived at the facility for a few years. The Administrator stated that the facility does have inventory policies but the facility did not update the inventory sheet when residents brought in new items to the facility. During an interview on 9/28/22 at 11:40 p.m. the Administrator verified that she could not locate an inventory sheet for Resident #10. During an interview on 10/6/22 at 11:00 a.m. Staff H, Regional Nurse Consultant (RNC), reported that she expected inventory sheets to be completed upon admission. The RNC stated the inventory sheet is a living document and is expected to be updated when new items are brought in for the residents. The RNC reported inventory sheets will be added to resident admission packets going forward.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44474 Based on facility record review, staff interviews, and facility policy review the facility failed to hold quarterly Quality Assessment and Assurance (QAA) meetings. The facility reported a census of 25. Findings include: The facility provided the Quarterly QA (Quality Assurance) meeting minutes for the following: a. January, February, and March quarterly meeting dated 3/25/22 b. April, May, and June quarterly meeting dated 7/19/22 The Quality Assurance Performance Improvement (QAPI) Plan policy dated 2021 indicated that in order for the QAPI Committee to successfully achieve its mission, the members should meet at least monthly and more often as needed to identify issues with respect to which QAPI activities are necessary. Additional meetings of the QAPI Committee should be scheduled as deemed necessary by the QAPI Program Committee Chairperson. Recommended meeting frequency is monthly. On 9/29/22 at 1:17 p.m. the Administrator confirmed that the corporate office wanted meetings to be held monthly but no less than quarterly. The Administrator added that she did not have any records of QAA meetings taking place prior to 3/25/22.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on observations, facility policy review, staff interviews, and the Centers for Disease Control and Prevention (CDC), the facility failed to provide care for a resident in a manner to prevent infection for 2 of 3 residents reviewed (Resident #2 and Resident #1). In addition the facility failed to cover the clean linen to prevent exposure. The facility reported a census of 25 residents. Findings include: 1. On 10/4/22 at 12:30 PM observed Staff B, Certified Nurse Assistant (CNA), and Staff C, CNA, provide perineal care for a resident, while Staff D, Licensed Practical Nurse (LPN), observed. Staff B took off her gloves, reached for something on her uniform, and told Staff D that she was used to having hand sanitizer attached to her uniform. Staff B then put on new gloves without performing hand hygiene. Staff B changed her gloves once more during the perineal care procedure without performing hand hygiene. Staff C changed her gloves a total of 3 times during the perineal care procedure without performing hand hygiene after removing gloves. The Handwashing Hygiene for Healthcare Providers CDC guidelines revised 1/8/21 directed that multiple opportunities for hand hygiene may occur during a single care episode to include immediately after glove removal. On 10/10/22 at 4:51 PM, the Regional Nurse Consultant (RNC) reported that she would expect hand hygiene to be performed after removing gloves. 2. On 9/26/22 at 10:57 AM observed an uncovered linen cart in the hallway with clean linen. On 9/27/22 at 9:10 AM noted an uncovered linen cart in the hallway that contained clean linen. On 9/28/22 at 1:08 PM noticed an uncovered hopper that contained clean linen in the hallway. The Laundry policy revised 2021 directed the following: 1. Cover clean linen to protect from contamination during transport. 2. Cover stored linen to protect from contamination until the linen is distributed for resident use. On 10/10/22 at 4:53 PM, the RNC reported that she would expect linen carts to be covered when in areas of resident access. 44474 3. Resident #1's MDS assessment dated [DATE] included diagnoses of muscle weakness, cerebral palsy and asthma. The MDS identified a BIMS score of 14, indicating no cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/6/22 at 10:44 a.m. observed Staff C, Certified Nursing Assistant (CNA), and Staff M, CNA, providing care to Resident #1. Staff M performed hand hygiene prior to applying gloves, and then took a pair of gloves out her pocket for Staff C. Staff C applied the gloves and proceeded to pull the blankets back with her gloves on. After removal of the blanket exposed a wet sheet of urine that Resident #1 told Staff C. Staff C without changing her gloves or completing hand hygiene assisted Resident #1 with moving her legs. Staff M applied gloves out of her pocket prior to performing perineal care. Staff M without changing her soiled gloves assisted Resident #1 to lie on her left side to complete care. Staff C removed her soiled gloves and applied another pair of gloves without performing hand hygiene. While wearing used dirty gloves, Staff M assisted Staff C with rolling Resident #1 back over the soiled incontinence brief. Staff C and Staff M removed their soiled gloves, but did not perform hand hygiene prior to assisting Staff M with applying a clean incontinence pad. Staff C and Staff M finished assisting Resident #1 get comfortable and then they completed their hand hygiene. On 10/13/22 at 10:17 the MDS nurse revealed that she would expect them to perform hand hygiene everytime there is a glove change.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44474 Based on observations and staff interviews, the facility failed to maintain a clean, orderly and homelike environment in the laundry facilities. The facility failed to keep clean linen separate from soiled linen due to only one door to enter or exit the laundry room. Observations showed the laundry room had clean clothing right next to the door where the clean and dirty laundry enter or exit the room. The facility identified a census of 25. Findings include: On 9/21/22 at 3:42 p.m. during the tour of the laundry room with the Maintenance Director noted the laundry room only had one door to enter or exit the laundry room. Observed clean laundry hanging uncovered by the entrance to the laundry room and a dark red cloth in the dryer. The Maintenance Director revealed the facility only had one person who did the laundry and they worked only five days a week. The Maintenance Director added that if the facility did not have laundry staff scheduled then he is the only one who could do the laundry and he is unable to do three full-time jobs. On 9/26/22 at 12:17 p.m. observed the laundry room. The observation revealed an odor of dirty clothing and urine. The laundry had several bags tied shut sitting on the floor in the basement ready to be washed. Noted clean clothing lying on the table ready to be folded and clean clothing hanging on a rack uncovered by the entrance to the laundry room. On 9/28/22 at 10:16 a.m. the laundry room had a strong odor of urine when entering the laundry room. Inside the laundry room contained an uncovered bin lined with a plastic bag filled with soiled bed pads. Clean laundry appeared to be laying in a pile on the table in the laundry room and clean clothing hanging on a rack uncovered by the entrance to the laundry room. The washing machine and the dryer were running. The Resident Rights and Dignity Management policy dated August 2021 directed that residents be provided a safe, clean, comfortable, and homelike environment. The Laundry Services policy dated June 2016 indicated that the facility would strive to protect residents and employees from nosocomial facility-acquired infections. The facility would reduce the risk of cross-infection by utilizing hygienic practices for the handling and processing of soiled linens. The policy continues to direct to separate the clean and soiled processing areas of the laundry with physical barriers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165344	A. Building B. Wing	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on personnel record reviews, facility policy review, and staff interviews, the facility failed to provide an updated dependent adult abuse training for 1 of 5 employees reviewed (Staff G). The facility identified a census of 25 residents. Findings include: Staff G's, Registered Nurse, personnel record indicated a hire date of [DATE]. The personnel file included a dependent adult abuse training certificate that expired in [DATE]. On [DATE] at 4:07 p.m. the Administrator revealed she would check and see if she could find a current dependent adult abuse training certificate for Staff G. During a follow-up interview on [DATE] at 1:17 p.m. the Administrator verified that Staff G did not have an updated dependent adult abuse training certificate. The Administrator reported that she removed Staff G from the floor until completion of the training. The Administrator added that she expected the staff to have their dependent adult abuse training current. The Freedom Of Abuse, Neglect And Exploitation; Abuse Prevention: Fast Alerts policy dated [DATE] directed that employee, resident, responsible party training regarding: Abuse identification, reporting, prevention, screening, investigation, protection. Training will occur upon hire and annually thereafter unless performance indicates additional training is needed. The Iowa Dependent Adult Abuse Training policy dated 2022 revealed Iowa staff are required to receive Dependent Adult Abuse Training within 6 months of hire and also annually. The Iowa Board of Nursing Mandatory Training on Abuse Identification and Reporting - FAQs instructed that a licensee who regularly examines, attends, counsels or treats children or dependent adults in Iowa is required to complete training related to the identification and reporting of child/dependent adult abuse. The Dependent Adult Abuse Services - Information Registry, S235b.16 dated [DATE] directed that a person required to report cases of dependent adult abuse pursuant to sections 235B.3 and 235E.2, other than a physician whose professional practice does not regularly involve providing primary health care to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling, or treatment of adults on a regular basis. The person shall complete at least two hours of additional dependent adult abuse identification and reporting training every three years. If the person completes at least one hour of additional dependent adult abuse identification and reporting training prior to the three-year expiration period, the person shall be deemed in compliance with the training requirements of this section for an additional three years.