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	02/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on observation, clinical record review, staff interviews, and policy review the facility failed to provide safe transfer techniques for 2 of 2 residents reviewed (Residents #1 and #5). The facility transferred Resident #1 with only 1 staff member, when they required 2 assistance for transfers. In addition, the facility failed to use a gait belt for an assisted transfer of Resident #5. The facility reported a census of 18 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified the inability to conduct a Brief Interview for Mental Status (BIMS), due to them rarely/never understood and displayed no speech. The MDS listed Resident #1 as dependent for chair/bed to chair transfers. The MDS included diagnoses of Alzheimer's, heart failure, muscle wasting and atrophy (thinning of muscle mass), anxiety disorder, and depression. The Care Plan Focus with a target date of 3/16/25, indicated Resident #1 had a risk for decline in activities of daily living (ADL) function related to a diagnosis of dementia. The Care Plan included an Intervention that Resident #1 required assistance of 2 staff with a gait belt for all transfers and ambulation. Interview on 2/19/25 at 2:12 PM, Staff C, Certified Nurse Aide (CNA), stated she normally transferred Resident #1 with assist of 1 and a gait belt prior to her discharge, but did think she was an assist of 2. Interview on 2/19/25 at 3:51 PM, Staff D, CNA, stated she always transferred Resident #1 by herself as she didn't know she was an assist of 2 staff for transfers. 2. Resident #5's Minimum Data Set (MDS) assessment, dated 1/30/25, identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Resident #5 required substantial to maximal assistance from staff for chair/bed to chair transfers. The MDS included diagnoses of diabetes, stroke, depression, chronic obstructive pulmonary disease (long-term lung disease), chronic kidney disease, and cellulitis (infection of the skin) of unspecified part of limb. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/24/25 at 11:15 AM, observed Staff A, CNA, in the back-lounge area transfer Resident #5 from a wheelchair (w/c) to the weight scale and back to the w/c without a gait belt. Instead of using a gait belt, Staff held Resident #5's left arm with her hands. The Administrator (ADM) and Director of Nursing(DON) were present in the room. Interview on 2/24/25 at 11:25 AM, Staff B, CNA, reported Resident #5 is an assist of 2 with a gait belt for transfers and she would use a gait belt for all resident transfers that required assistance. Interview on 2/24/25 at 11:38 AM, Staff A stated she normally transferred Resident #5 as an assist of 2. Staff A acknowledged she transferred Resident #5 from a w/c to the scale and back to the w/c without a gait belt with assist of 1. She verified she should have used a gait belt. Interview on 2/24/25 at 11:41 AM, the ADM denied observing Staff A transfer Resident #5 without a gait belt. The ADM stated they expected the staff to use a gait belt for transfers with any resident that needed assistance and follow the resident's Care Plan for the required assistance needed to transfer a resident. Facility policy, Safe Lifting and Movement of Residents, effective October 2024, instructed in order to protect the safety and well being of staff and residents, and to promote quality care, the facility used appropriate techniques and devices to lift and move residents. The staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts) devices. Facility policy, Using the Care Plan, effective October 2024, directed the Care Plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to be rendered.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40905 Based on observation, clinical record review, staff interviews, and policy review the facility failed to notify the Dietitian when a resident admitted to the facility. In addition, the facility failed to contact the physician regarding recommendations from the Dietitian regarding nutritional supplementation for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 18 residents. Findings include: Resident #5's Minimum Data Set (MDS) assessment, dated 1/30/25, identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Resident #5 required substantial to maximal assistance from staff for chair/bed to chair transfers. The MDS included diagnoses of diabetes, stroke, depression, chronic obstructive pulmonary disease (long-term lung disease), chronic kidney disease, and cellulitis (infection of the skin) of unspecified part of limb. On 2/24/25 at 10:00 AM, observed Resident #5 lying in bed dressed in a gown. Resident #5 said she didn't usually like the food. She added she usually ate in her room most of time, but sometimes went out to eat in the dining room. Resident #5 explained the staff gave her soup the night before with potatoes and carrots not done. Resident #5 stated sometimes the staff provide an alternate if she didn't like the menu item. Resident #5 reporting she knew she lost some weight and she didn't receive any dietary supplement. The Admission Summary dated 1/24/25 at 1:57 PM identified Resident #5 admitted to the facility. An email between the Dietitian and the facility dated 1/27/25 at 6:11 PM labeled Nutrition Recs (Recommendations). The body of the email reflected the Dietitian notified the facility of their recommendations. The list included recommendations for Resident #5. The Dietary Consultant Review Recommendations dated 1/27/25 indicated the facility didn't notify the Dietitian of Resident #5's new admission. The form included the following orders: a. Add diet to electronic health record (EHR). b. Request reweight c. Increase vitamin C to 500 milligrams twice a day (BID). d. Add Juven (Nutritional supplement used to support wound healing) 1 packet BID for 60 days. e. Add zinc every day. Resident #5's February 2025 Medication Administration Record (MAR) listed the following orders dated: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. 2/1/25: Monthly weight as indicated every day shift starting on the 1st every month for monitoring. - Documented on 2/1/25 as 147 lbs. b. 2/25/25: Zinc oral tablet, give 1 tablet by mouth once a day for supplement. c. 2/24/25: Ascorbic acid tablet (vitamin C) 500 MG, give 1 tablet by mouth 2 times a day for supplement. d. 2/24/25: Arginaid oral packet (nutritional supplement), give 1 packet by mouth two times a day for supplement for 60 Days. Interview on 2/24/25 at 10:10 AM, the Director of Nursing (DON) explained the Dietitian worked remotely, and they notify her of new admissions. She usually communicated with the Dietary Supervisor. Interview on 2/24/25 at 11:47 AM, the Dietitian stated she worked remotely with the facility. The facility did the resident's monthly weights and then she downloaded a report. The Dietitian stated she tracked the residents' weights and puts them in a monthly report for those triggered for significant weight loss. The monthly report varies when she does it based on when the facility completes the weights. The Dietitian reported being off for vacation, so she just pulled a report on Friday and saw the significant weight loss for Resident #5 with the weight completed on 2/1/25. The Dietitian stated she asked the facility to reweigh Resident #5 on 1/27/25 when she completed the initial assessment due to hospital notes documentation of weights of 144 lbs. on 11/28/24 and 165 lbs. on 1/20/25. Due to Resident #5's weight on 1/24/25 at admission to the facility, she weighed 178. The Dietitian reported she also made recommendations for Resident #5 to increase her Vitamin C to 2 times a day, add Juven 1 package daily, and add Zinc. The Dietitian explained she didn't receive a reweigh for Resident #5 and the facility didn't start her recommendations. Interview on 2/24/25 at 3:00 PM, the DON explained she received the Dietitian recommendations via email, she noted the recommendations, provided recommendations to the Nurse Practitioner (NP), and then she put in the orders. The DON stated she didn't recall any recommendations for Resident #5. The DON reviewed her computer and confirmed she received recommendations for Resident #5 via email on 1/27/25. The DON reported she didn't have confirmation of the NP receiving the dietary recommendations. The facility policy Weight Assessment and Intervention F 692 effective October 2024, documented they would obtain reweights as needed within 24 hours.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on clinical record review, staff interview and policy review, the facility failed to limit a PRN (as needed) antipsychotic drug to 14 days. In addition, the facility failed to document non medical interventions prior to administering a PRN antipsychotic drug for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 18 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) shouldn't be conducted as they are rarely/never understood. The MDS included diagnoses of medically complex conditions, cancer, heart failure, Alzheimer's disease, non Alzheimer's dementia, anxiety disorder, and bi polar disorder. The MDS indicated Resident #2 received antipsychotic medication during the lookback period. The Care Plan Focus with a target date of 3/30/25 indicated Resident #2 had a history of being physically aggressive related to history of harm to others. The Care Plan included the following Interventions: a. Instructed the staff to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, and pain, etc. b. When he becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, ensure he is safe, staff to walk calmly away, and approach later. Resident #2's January 2025 Medication Administration Record (MAR) included an order dated 1/13/25 for haloperidol (Haldol) lactate oral concentrate, 1 milliliters (ml) by mouth every 6 hours PRN behaviors related to dementia. The staff documented Resident #2 received the medication on 1/22/25 and 1/28/25. Resident #2's February 2025 MAR included an order dated 1/13/25 for haloperidol (Haldol) lactate oral concentrate, 1 ml by mouth every 6 hours PRN behaviors related to dementia. The staff documented Resident #2 received the medication on 2/2/25 and 2/8/25. Resident #2's progress notes lacked documentation of non medicinal interventions before administering the PRN medication. The progress notes further lacked documentation of adverse drug reactions, side effects or effectiveness of the use of the haloperidol. During an interview 2/20/25 at 3:02 PM, the Administrator stated he understood and expected PRN antipsychotic medication not be prescribed past 14 days without a physical in person exam. The Administrator acknowledged Resident #2 had a prescription of haloperidol lactate oral concentrate over 14 days, from 1/13/25 to 2/12/25, without an exam at or before 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 2/24/25 at 3:20 PM, the Administrator stated they expected the staff to document behaviors and attempt non medicinal interventions prior to administering PRN antipsychotic medications.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 40905 Based on review of the facility's Quality Assurance Performance Improvement (QAPI) policy, the facility's past surveys, review of plan of correction audit forms, and staff interview, the facility failed to correct their own deficiencies for 4 of 5 areas of concern. The facility reported a census of 18 residents. Findings include: On 2/24/25 at 2:00 PM, a review of the F758 (regulation for use of psychotropic medication) audit sheets with the Director of Nursing (DON) and the Administrator (ADM) listed audit dates of 2/7/25 and 2/14/25. The documentation listed the DON marked yes, they re educated licensed nursing staff and Certified Medication Aides of the expectation of documenting nonpharmacological interventions prior to administering psychotropic medications and the DON would audit psychotropic PRN (as needed) medication administration record to ensure nonpharmacological intervention weekly X 4 weeks. The form included a resident's name with the DON's initials documented. When asked if they found any noncompliance when completing the audit, the DON responded she would have corrected and fixed at that time if so. When inquired if the DON had any documentation if she provided more education or the audit was not in compliance, the ADM replied it would be documented on the sheet below the audit checks and the form didn't have documentation of a concern with the audit being in compliance. The DON confirmed the audits were in compliance. Interview on 2/24/25 at 2:30 PM, the ADM confirmed the audits on 2/7/25 and 2/14/25 shouldn't be in compliance as Resident #2 received a PRN psychotropic medication without documentation of behaviors and nonpharmacological interventions. The survey identified the following concerns during the current survey that the prior survey team cited during the surveys in the past.: a. QAPI program and plan. b. Free of accidents, hazards, and supervision. c. Free from unnecessary psychotropic Medications/ PRN (as needed) Use. d. Notification of Changes(Injury/Decline/ Room, etc.) The facility's policy, QAPI Plan and Program effective August 2024, directed the facility shall develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focused on indicators of the outcomes of care and quality of life. Interview on 2/24/25 at 3:00 PM, the ADM acknowledged the concerns with repeated deficiencies and concerns with QAPI. The ADM felt like the facility worked very hard and just couldn't get a break. The ADM further stated the facility still used some agency nurses but no longer Certified Nurse Aides, and hopes that will help.