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	07/03/2024

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

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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 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** 49056 Based on record review and staff interviews the facility failed to provide professional standards of care by not providing supervision with ambulation per physician orders for 1 of 15 residents reviewed (Resident #13). The facility reported a census of 15 residents. Findings include: Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified the facility didn't complete a Brief Interview for Mental Status (BIMS) score as they were rarely or never understood. The MDS included diagnoses of non Alzheimer's disease, anxiety disorder, and depression. Review of signed physician orders dated 2/7/24 included an order for Resident #13 to have supervision when walking long distances in the hallway. Resident #13's Care Plan lacked information regarding supervision with ambulation. On 7/2/24 at 4:34 PM the Director of Nursing (DON) reported Resident #13 had numerous falls in the last six months, and the facility didn't put the order from 2/7/24 in place. Resident #13 continued to independently ambulate and transfer.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 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** 49056 Based on clinical record reviews, observations, staff interviews and policy review, the facility failed to complete a root cause analysis or determine a conclusion with each fall, put effective interventions in place, and provide levels of assistance as directed by the Care Plan for 1 of 1 resident reviewed (Resident #13). Resident #13 had a risk for falls with a history of repeated falls, with 15 falls in the previous 6 months. The facility reported a census of 15 residents. Findings include: Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified the facility didn't complete a Brief Interview for Mental Status (BIMS) score as they were rarely or never understood. The Staff Assessment for Mental Status indicated she had a short and long-term memory problem, with severely impaired decision-making skills. The MDS included diagnoses of non Alzheimer's disease, anxiety disorder, and depression. Resident #13 had 2 falls without injury since her admission/entry, reentry, or her prior assessment. The Facility Incident Reports (IR) documented from February 2024 June 2024 listed Resident #13 fell on : a. 2/28/24 b. 3/14/24 c. 3/15/24 d. 3/28/24 e. 5/2/24 f. 5/14/24 g. 5/16/24 h. 5/19/24 i. 5/27/24 j. 6/7/24 k. 6/10/24 l. 6/12/24 m. 6/13/24 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	n. 6/14/24 o. 6/26/24 The Care Plan with a target date of 7/23/24 reflected Resident #13 had a risk for injury from falls related to a diagnosis of dementia and the use of psychotropic medication. The Interventions directed the following: a. 2/28/24 Gripper strips to the floor next to the bed. b. 3/14/24 Staff to encourage resident to wear glasses to help with visual perception c. 3/15/24 Staff to provide adequate lighting especially at night d. 3/28/24 Staff to assure residents wheelchairs are far enough apart to allow other residents to walk through to reduce possibility of tripping e. 5/2/24 Resident is to be toileted every two hours throughout the day f. 5/14/24 Resident to wear proper fitting pants that do not drag on the floor g. 5/16/24 Dycem on couch while resident is on couch. Resolved (resident will not leave Dycem in place 5/28/24) h. 5/19/24 Nonskid strips in front of couch i. 5/27/24 Educated CNA to walk resident to room after meals and offer toilet j. 6/7/24 Staff to assist resident onto the couch when see resident going to sit on couch k. 6/10/24 Staff to offer resident bathroom after meals l. 6/12/24 Staff to offer resident bathroom first thing in the morning before breakfast m. 6/13/24 Psych to see for medication evaluation n. 6/14/24 Fax sent to physician that resident will continue to have falls due to decline in medical condition (late onset Alzheimer's) o. 6/26/24 admitted to Gentiva Hospice The facility policy named Fall Standard revised 8/20/21 indicated the facility strived to reduce the risk for falls and injuries by promoting the implementation of the Risk Reduction: Falls and Injuries Program. Residents are assessed for the fall risk factors. The interdisciplinary team works with the residents and family to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. a. Assess and review risk factors for falls and injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. The facility considered all new admissions high risk for falls. The staff will assess and document on them on every shift for a minimum of 3 days (72 hours). ii. Review the completed Nursing Admission Assessment. iii. Complete the Fall Risk Assessment. b. Review/evaluate other assessments and interdisciplinary assessments. c. Complete the individual resident Care Plan. d. Implement the Interim Baseline Plan of Care Fall Risk Reduction based on individual resident needs. The Certified Nurse Aide (CNA) Kardex (Pocket Care Plan) will identify residents as high risk for falls. e. Communicate interventions during shift report and clinical rounds to the care teams as appropriate. f. Provide training to staff as appropriate. g. Review and revise interdisciplinary Plan of Care at subsequent Care Plan meetings. h. Educate residents and family as indicated. On 7/3/24 at 12:40 PM when asked about root cause analysis and interventions for falls, the Director of Nursing (DON) and Regional Nurse Consultant reported they go through and ask the five whys to get to the root cause analysis. The facility instructed the floor nurses to put the immediate intervention in place. The DON reviewed the intervention to make sure it is appropriate. If a resident has increased falls, they talk about it in the morning meeting and discuss the interventions during the care management meetings. They discuss the top 5 topics. If there are interventions put into place, they place them in the communication book, and the DON updates the Care Plan.

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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** 46875 Based on clinical record review, staff interviews, hospital record review and policy review the facility failed to provide appropriate bowel management assessments, interventions and physician notifications to prevent a fecal impaction which resulted in a hospitalization for 1 of 1 resident reviewed (Resident #2). The facility reported a census of 15 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #2 required total assistance from staff for bed mobility, chair/bed to chair transfers, and toileting hygiene. The MDS reflected Resident #2 didn't transfer to the toilet during the assessment period. The MDS listed Resident #2 as always incontinent of bowel and bladder. Resident #2's MDS included diagnoses of cerebral palsy (movement disorder due to damage in the brain responsible for muscle control), paraplegia (impairment in lower extremities), chronic pain, constipation, anxiety and depression. The Care Plan with a target date of 9/12/24 reflected Resident #2 had a history of constipation, incontinence of bowel and bladder and continually declined for suppositories as an intervention. The Care Plan directed the following: Incontinent care as indicated. Medications as ordered. Notify MD (Doctor) as needed. Observe Resident #2 for alterations in bladder such as oliguria (low urine output), dysuria (pain/discomfort during urination), frequent urination during care. Observe Resident #2 for alteration in bowel patterns such as constipation, diarrhea during care. Offer and encourage fluids as tolerated. The Care Plan lacked information on Resident #2's bowel history and her normal bowel pattern. The Care Plan lacked direction on when and/or how often to do a bowel assessment. In addition, the Care Plan didn't address what to do if Resident #2 refused bowel medications and/or bowel management interventions. The Care Plan lacked direction on when to notify the physician regarding Resident #2's constipation. A Progress Note dated 1/28/24 at 4:28 AM described Resident #2 as on day 10 without having a bowel movement (BM). The note indicated Resident #2 refused any use of suppositories, enema, or assistance. The note indicated Resident #2 did take routine bowel medication and reported she passed gas. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated 1/31/24 at 5:49 AM listed Resident #2 as on day 13 without a BM. The note documented Resident #2 refused a suppository or enema. The staff educated her on the possible outcome of not having a BM for so long. A Progress Note dated 2/6/24 at 5:32 AM detailed Resident #2 as on day 19 without a BM. The note documented staff offered an enema and suppository which Resident #2 refused. The note indicated the staff explained to Resident #2 the possible outcome of a bowel obstruction or a ruptured colon. Resident #2 reported she knew of these possible outcomes, but did not want to try anything. The Progress Notes from 1/19/24 to 2/6/24 lacked documented bowel assessments and Physician notification regarding Resident #2's constipation and refusal of bowel management interventions. A Progress Note titled Dietary Progress Note dated 3/25/24 at 9:34 AM documented Resident #2's last BM as 3/13/24, on day 12 without a BM. The note documented staff monitors bowel functions due to high risk for fecal impaction related to chronic constipation with frequent refusals for bowel regimen. Resident #2 preferred to alleviate constipation as able with fluids and fruits of kiwi, grapes, and oranges. The Progress Notes from 3/13/24 to 3/25/24 lacked documentation of Resident #2 having constipation, bowel assessments, Physician notifications, and lacked if the staff offered or tried PRN (as needed) bowel interventions. A Progress Note dated 5/3/24 at 2:28 PM indicated Resident #2 received a PRN Senna Time S (laxative) tablet 8.6 50 MG (milligrams) one tablet for constipation. The note documented listed Resident #2 on day 5 with no BM. The note lacked a documented bowel assessment. A Progress Noted dated 5/3/34 at 3:56 PM listed the PRN administration of the Senna Time S tablet as ineffective. The note lacked documentation of other attempted or tried bowel interventions. The note lacked Physician notification regarding Resident #2's constipation and that she had PRN medication without results. A Progress Note dated 5/7/24 at 2:09 PM documented Resident #2 on day 8 without having a BM, and she refused to take any medication. The note indicated Resident #2 reported this as normal for her. A Progress Note dated 5/9/24 at 1:20 AM documented Resident #2 continued to have no BM for the previous 9 days and refused a suppository or enema. A Progress Note dated 5/10/24 at 2:20 AM documented Resident #2 on day 10 without a BM and she refused to take a suppository or enema. A Progress Note titled Long Term Care Evaluation dated 5/10/24 at 4:55 PM indicated Resident #2 didn't have a BM for 10 days and she refused to take extra laxatives for constipation. Resident #2 reported this as normal and said she could go up to 20 days before having a BM. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated 5/13/24 at 1:05 PM documented Resident #2 laid down after lunch due to not feeling well. The note described Resident #2 as hot, clammy, and nauseated. According to the note the staff gave her an emesis basin and after 15 minutes Resident #2 did not vomit. Resident #2 had a temperature of 96.9 and continued having nausea. The progress note lacked a full set of vital signs, bowel assessment, and physician notification regarding her change in condition. A Progress Note dated 5/13/24 at 9:38 PM documented Resident #2 requested an enema due to abdominal pain and discomfort. The note lacked a documented bowel assessment. A Progress Note dated 5/13/24 at 11:14 PM documented the enema as ineffective as she had a small amount of brown liquid. The progress note lacked follow up documentation on Resident #2's abdominal pain/discomfort, if they offered her other bowel management interventions, and vital signs. A Progress Note titled Interact SBAR (Situation, background, assessment, and recommendation) Summary for Providers dated 5/14/24 at 9:26 AM documented Resident #2 had a change in condition that included abdominal pain, abnormal vital signs, constipation or impaction, nausea/vomiting and shortness of breath. At the time of the evaluation Resident #2 had vitals of blood pressure 172/104, pulse of 94 beats per minute, respiration of 20 breaths per minute, temperature of 97.1, and oxygen saturation 83% (oxygen in the blood) on room air. The note documented Resident #2 didn't have a BM since 4/28/24, she had a bisacodyl tablet and PRN enema without relief. The assessment described Resident #2's abdomen as hard and distended with no active bowel sounds heard through auscultation (listening). The note documented a recommendation for an x ray. A Progress Note on 5/14/24 at 4:39 PM documented at 2:30 PM when the nurse went to give Resident #2 medication, she reported she didn't want to wait for the portable x ray to come as she had extreme pain and wanted to go to the hospital. The note documented the nurse called the Nurse Practitioner's (NP) office and received a telephone order to send Resident #2 to the hospital via ambulance for evaluation and treatment for a possible bowel obstruction. The note further documented a staff member at the NP's office stated the NP said this morning they could send Resident #2 out. According to the note the nurse didn't know she could send Resident #2 out when she called the office that morning. At 2:50 PM, the ambulance arrived and transported Resident #2 to the hospital. A Progress Note on 5/14/24 at 5:40 PM indicated the hospital admitted Resident #2. The Progress Notes from 4/28/24 to 5/12/24 lacked documented bowel assessments and Physician notification regarding Resident #2's constipation and refusal of bowel management interventions. The Progress Notes on 5/13/24 lacked documented bowel assessments and physician notification that Resident #2 didn't feel well, had complaints of abdominal pain/discomfort and that the PRN enema she received didn't have results. The chart didn't have further documentation on Resident #2's condition from 5/13/24 at 11:14 PM until 5/14/23 at 9:26 AM when Resident #2 voiced complaints of abdominal pain/discomfort with abnormal vital signs and shortness of breath. The Hospital Record titled Abdomen X ray dated 5/14/23 revealed a large amount of retained stool in the rectum consistent with fecal impaction. The report listed upstream gaseous dilation of the colon likely related to fecal impaction. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospital Record titled CT (computed tomography) abdomen and pelvis with contrast dated 5/15/24 revealed the following: a. Marked distention of the colon with massive volume stool b. Scattered fluid filled small bowel loops throughout the abdomen most likely related to the colon distention/ileus c. No free intraperitoneal gas d. Numerous undigested tablets in the colon and in the small bowel. The Hospital Record titled Abdomen X ray dated 5/16/24 revealed Resident #2 would likely benefit from disimpaction due to a massive amount of stool in the rectosigmoid region and a moderate stool in the descending colon with small stool proximally. The x ray revealed multiple dilated loops of small bowel bile measuring up to 3.4 cm (centimeters) and a dilated colon measuring up to 9.8 cm. The x ray findings reflected constipation. A General Surgery Consultation Report dated 5/15/24 revealed the hospital admitted Resident #2 with significant abdominal distention secondary to fecal impaction. According to the history and physical, Resident #2 had a long history of constipation with having bowel movements once every 15 to 20 days and had a hard time breathing due to the distention. The Physical examination revealed Resident #2's rectal vault had firm hard stool and the hospital staff performed a disimpaction at the bedside. Once disimpacted Resident #2 started passing some flatus (gas) and felt better. Discussion with nursing staff reported Resident #2 had several large bowel movements with soap suds enema after disimpaction. A Progress Note dated 5/16/24 at 5:18 PM indicated Resident #2 readmitted to the facility. A Progress Note dated 7/2/24 at 12:46 AM documented the staff offered Resident #2 an enema due to 9 days with no BM. The note documented Resident #2 refused the enema and wanted to wait a few more days. The note lacked a documented bowel assessment and Physician notification related to the constipation and refusing the enema. The Progress Notes from 6/24/24 to 7/1/24 lacked documentation of Resident #2's constipation, bowel assessments, physician notifications, if the staff offered or tried bowel interventions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/24 at 9:15 AM, Resident #2 reported she tried to eat certain foods to make herself go to the bathroom. She stated she ate fruits, chocolate, fiber cereal, frosted mini wheats, and raw veggies. She stated she tried all constipation interventions including over the counter and prescription medications. She stated the prescription medications are really assaultive to her body and if you start them then you have to keep up with them. She said she likes to try non assaultive interventions first. She reported the staff gave her laxatives routinely every day. She stated she didn't want to overdue the medications as it causes her BM's to become liquid and that embarrasses her. She stated she will refuse PRN laxatives as the medications hurt her stomach. She stated she will choose to do an enema over milk of magnesia (MOM). She reported MOM was disgusting and didn't work for her as she took it for over 5 years. She reported Miralax (laxative powder) didn't work either. She reported she had a megacolon (large colon) and had dealt with constipation problems since being 3 years old. She reported she also tried probiotics and they hurt her stomach. She stated she didn't like to talk about issues with constipation as could prevent her from going. When asked if the nurses assessed her when she had constipation, she said the nurses listened to her stomach and asked her if it hurts. She Said she got embarrassed asking for an enema. She reported if you monkey around with her too much it hurt her dignity. She reported being scared when she went to the hospital the last time. She stated she had oxygen at 2 liters on and couldn't breath. She stated it felt like she having an asthma attack. She reported she planned to ask for an enema the evening of 7/3/24. On 7/3/24 at 10:00 AM, Staff A, RN (Registered Nurse), reported Resident #2 wouldn't take laxatives when offered. She stated Resident #2 had a pattern of going multiple days without a BM. Staff A reported if a resident had constipation she would assess bowel sounds, eating, and nausea. Staff A stated they should document the assessment in the progress notes along with physician notification. Staff A stated that morning the report reflected Resident #2 on day 10 without a BM. She stated she would offer Resident #2 additional laxatives that morning. Staff A reported Resident #2 got scheduled/routine laxatives. She stated she didn't know Resident #2 went 9 days without a BM as of the day before. On 7/3/24 at 10:15 AM, the DON (Director of Nursing) reported she expected the nurses to check bowel sounds and chart the findings in the progress notes. She said she also expected the nurses to notify the Physician. The DON reported Resident #2 had a history of going multiple days (10 20) without having a BM. The DON reported Resident #2 did what she wanted to do. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/24 at 11:01 AM, Staff B, LPN, reported it as normal for Resident #2 to go 18 days without a bowel movement. She described Resident #2's stomach as more distended and harder on 5/14/24. Staff B reported she couldn't hear bowel sounds and described Resident #2 as very uncomfortable. She stated Resident #2 agreed to call the DR. Staff B reported the NP called back about 1 1/2 hours later and gave a verbal order for an x ray. Staff B said she filled out the SBAR form while on the phone talking to the NP and faxed the form to the office which included the abnormal vital signs. Staff B stated once Resident #2 got out of bed and in her chair her pulse ox went up. She stated she gave Resident #2 her medications including pain pills and her blood pressure went back down. Staff B reported she didn't know where they documented the follow-up vital signs. Staff B stated she called for a portable x ray. Resident #2 became anxious so she called the NP's office back and got an order to send Resident #2 to the emergency room . Staff B reported Resident #2 did not want oxygen on as she couldn't breathe with it in her nose. Staff B stated she had to plead with Resident #2 to go to the hospital. Staff B reported she told Resident #2 that she would feel better. She stated as the day went on Resident #2 felt worse and decided to go to the hospital. Staff B reported if Resident #2 went 2 3 days without a BM then they would offer her prune juice and if 3 4 days without a BM they would offer/give her a laxative. She stated Resident #2 refused both interventions every time. She said after day 4 you offer/give an extra PRN Senna plus and wait for her to poop. Staff B reported if a resident went 3 4 days without a BM she would listen to bowel sounds. She stated she didn't believe she documented the bowel sounds anywhere. Staff B stated she did not believe the facility had charting or assessment expectations in place. Staff B reported the night shift looked at the BM records nightly and reported who needed bowel interventions. She stated the dayshift would complete the follow ups. She described Resident #2 as very strong minded and if she didn't want something, it wouldn't happen. On 7/3/24 at 12:39 PM, the DON verified she couldn't find any further documentation on bowel assessments prior to her hospitalization on [DATE]. On 7/3/24 at 3:45 PM, the NP reported she knew Resident #2 had a fecal impaction and went to the emergency room . She stated according to the office records on 5/14/24, they ordered an x ray of her abdomen. Resident #2 followed up in the ER after that. The NP reported she expected the facility to follow the standing orders for constipation. She stated the standing orders would include a suppository, fleets enema and a soap suds enema. The NP reported she was not surprised if Resident #2 refused additional laxatives or interventions. She described Resident #2 as very difficult. The NP reported having frustration with the long-term care and regulations. She stated Resident #2 had the right to refuse care and treatment. On 7/3/24 at 3:55 PM, Staff C, Regional Nurse Consultant reported the facility didn't have standing orders for constipation. A facility policy titled Incontinence Management revised October 2023 instructed the importance of remembering that a normal bowel pattern for most individuals as once every 1 3 days but should be based on the individual history and preference. The policy indicated the resident may require the use of stool softeners, laxatives, suppositories and occasional enema to alleviate constipation, remove fecal impaction and assist the resident to attain regular, soft bowel movements. Before implementing such medications the resident, responsible party, and physician should have a discussion.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46875 Based on the Center of Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (January 1st March 31) review, facility staffing assignments review and staff interviews, the facility failed to submit accurate staffing data for the PBJ Staffing Data Report. The facility reported a census of 15 residents. Findings include: The PBJ Staffing Data Report run date of 6/26/24 triggered for failure to have licensed nurse coverage 24 hours/day on the following infraction dates: 1/13/24, 1/22/24, 1/26/24, 2/5/24, 2/6/24, 2/27/24, 3/9/24, 3/10/24, 3/11/24, 3/21/24 and 3/25/24. Review of Facility Daily Assignment Sheets for the infraction dates reflected the Director of Nursing (DON), MDS (Minimum Data Set) Coordinator and agency staff members covered the nursing shifts. On 7/2/24 at 1:25 PM, the Administrator reported the salaried staff and agency staff didn't clock in and out. She reported she expected the salaried and agency staff to fill out a missed punch form. The Administrator reported if the salaried and agency staff do not fill out the form it would fall on the DON or Administrator to fill out the form. She stated they send the missed punch forms to Human Resources (HR) who put the forms in a file for the Payroll department to access and then Payroll completed the data submission for the PBJ reporting. On 7/2/24 at 3:40 PM, the Administrator acknowledged the submission of the data for the PBJ was not accurate and did not reflect the nursing hours that the nursing administration and agency staff members worked. She stated she would never leave the building without nursing coverage. A facility form titled PBJ procedure for CareWorks recordings dated 7/3/2024 documented the following procedure: a. Salaried nurses (DON and MDS Coordinator) fill out a company missed punch form. b. Give the form to the HR manager and/or Administrator. c. Send the form to Payroll Department via electronic mail, where they record the hours on the PBJ dashboard.

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	07/03/2024

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 49056 Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facilities past surveys, and staff interview, the facility failed to correct their own deficiencies for 3 of 6 areas of concern. The facility reported a census of 15. Findings include: The Quality Assurance Performance Improvement (QAPI) Plan described the facility's Mission as to maximize the quality of resident care, facility services through a continual, and proactive analysis of facility practices. The policy directed to accomplish the mission through a systematic and interdisciplinary study of facility resources and data. The listed the goal of the program as to empower staff by enabling them to develop creative and effective ways to successfully meet the needs of the facility's many customers. The purpose instructed to develop, implement and maintain an ongoing program designed to monitor and evaluate customer satisfaction and the quality of resident care, pursue methods to improve quality care and other facility services and to resolve identified problems. The facility had the following concerns identified at the current survey, previously cited at surveys in the past year: a. Services provided meet professional standards. b. Free of accidents/hazards, supervision. c. QAPI program/plan On 7/3/24 at 3:23 PM the Regional Nurse Consultant reported it is hard with agency staffing, as they just come in and do the job. The DON has to work the floor and can't always do her job duties.