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	12/05/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews and policy review, the facility failed to notify and document the physician and family for 3 of 10 residents reviewed (Residents #3, #11, and #9). The facility reported a census of 15 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. The MDS identified Resident #3 as dependent on staff for bed mobility, transfers, and toileting. The MDS included diagnoses of hypertension (high blood pressure), septicemia (life threatening infection in the bloodstream), cerebrovascular accident (CVA or stroke), right sided hemiplegia (paralysis or weakness affecting one side of the body), seizure disorder, traumatic brain injury (TBI), malnutrition (inadequate nutritional intake), and cellulitis (skin infection) of the right lower limb. The MDS reflected Resident #3 had one fall without injury. An Incident Report (IR) dated 8/15/24 at 7:45 PM indicated staff found Resident #3 on the floor in his room laying on his back all stretched out. He had his head near the door with his feet toward the bed. Resident #3 tried to get something and fell out of his wheelchair. The identified Resident #3 as incontinent and angry with staff and peers when he returned from his smoking break. The IR documented the staff notified the Administrator, Director of Nursing (DON), and physician of his fall. The IR and clinical record lacked documentation regarding family notification. An IR dated 11/28/24 at 2:15 PM documented staff heard Resident #3 yelling for help from his room. The staff observed Resident #3 on the floor on his left side in front of the bathroom door with his wheelchair behind him. Resident #3 explained he tried to pick something up off the floor when he slid out of the wheelchair. The facility educated Resident #3 on the importance of not leaning forward to pick up anything off the floor. The incident report and clinical record lacked documentation of notification to Resident #3's physician or his family of the fall. On 12/4/24 at 9:19 AM, the DON reported she couldn't locate any documentation that someone notified Resident #3's family of his fall on 8/15/24. (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 9:19 AM, the DON verified they didn't notify Resident #3's physician and family of his fall on 11/28/24. On 12/4/24 at 10:50 AM, the DON reported she expected someone to notify the physician and family of a fall. The facility policy titled Assessing Falls and Their Causes Guidelines revised October 2024 directed the nursing staff to notify the resident's attending physician and family after a resident fell in an appropriate time frame. 2. Resident #11's MDS assessment dated [DATE] identified a BIMS score of 9, indicating moderately impaired cognition. The MDS listed Resident #11 as independent with bed mobility, transfers, and toileting. Resident #11's MDS included diagnoses of hypertension (high blood pressure), anemia (low levels of iron in the blood), heart failure (heart didn't pump blood well), diabetes mellitus, and depression. A Progress Note dated 9/22/24 at 10:54 AM labeled Late Entry documented Resident #11 reported a CNA (certified nursing assistant) as verbally abusive. The note documented the Administrator completed a self-report to the state and suspended the CNA. The facility had the Social Services do weekly follow-ups with Resident #11 to ensure she had stable emotional health. Review of the clinical record lacked documentation that someone notified Resident #11's Physician of the allegations of abuse. On 12/3/24 at 12:50 PM, the DON (Director of Nursing) verified no one notified Resident #11's primary provider of the allegations of abuse. She stated she notified the mental health provider and thought that was enough. She stated she didn't know why she didn't notify the primary provider. On 12/4/24 at 8:51 AM, the Administrator reported she contacted the mental health provider and they had no recollection of the incident/allegations of abuse. The Administrator verified she couldn't locate the Physician's notification regarding the allegation of abuse. On 12/4/24 at 9:25 AM, the Administrator reported she expected someone to notify the Physician of an allegation of abuse. A facility policy titled Change in a Resident's Condition or Status F580 last approved October 2024 documented the facility staff shall promptly notify the resident, their Attending Physician, and resident representative of changes in the resident's medical/mental condition and/or status. The policy further documented that except in medical emergencies, notification will be made within twenty four hours of a change occurring in the resident's mental/medical condition or status. 49056 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #9's MDS assessment dated [DATE] identified a BIMS score of 1, indicating severe cognitive impairment. The MDS identified Resident #3 as dependent on staff for bed mobility, transfers, and toileting. The MDS included diagnoses of hypertension (high blood pressure), septicemia (life threatening infection in the bloodstream), cerebrovascular accident (CVA or stroke), right sided hemiplegia (paralysis or weakness affecting one side of the body), seizure disorder, traumatic brain injury (TBI), malnutrition (inadequate nutritional intake), and cellulitis (skin infection) of the right lower limb. Resident #9's EHR lacked notification to the family for a facility reported incident on 11/15/24. Interview on 12/5/24 at 3:30 PM the DON revealed she didn't think the facility notified the family of the facility reported incident. The DON remembered contacting the family regarding Resident #9's emergency room visit on 11/14/24. The DON explained she didn't notify the family until they were sure of the outcome of the incident. An electronic message from the Administrator on 12/6/24 at 5:01 PM revealed a text message between Administrator and family member. The Administrator asked Was the medication error discussed with you on 11/15/24 in regards to the Depakote we were investigating in our self-report? A response from the family member stated I don't remember, I think it was.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 46875 Based on clinical record review, Minimum Data Set (MDS) RAI (Resident Assessment Instrument) Manual, staff interviews, and policy review the facility failed to complete a comprehensive assessment within 14 days of admission for 1 of 1 resident reviewed (Resident #121). In addition, the facility failed to complete a comprehensive annual assessment in a timely manner for 1 of 10 residents reviewed (Resident #1). The facility reported a census of 15 residents. Findings include: 1. Resident #121 clinical census listed their admission to the facility as 11/14/24. Resident #121's MDS list reflected the following MDS' in progress and not completed with an assessment reference date (ARD) of 11/14/24 and 11/19/24. 2. Resident #1's Annual MDS had an ARD of 11/10/24 and reflected a status of in progress and not completed. On 12/3/24 at 2:30 PM, the DON (Director of Nursing) reported the prior management had a Corporate lady who completed the MDS' for the facility. She stated since the new company took over, they haven't addressed their expectation for completing the MDS'. She stated she tried to do some of the MDS' but she hadn't prioritized the MDS assessments, adding they didn't hire her to do the MDS'. She explained she had to work the floor as a charge nurse and didn't have time to do the DON role. She voiced frustration that she didn't receive training to do the DON role. The DON verified Resident #121 didn't have their admission MDS completed or started and was late. In addition, she added Resident #1 didn't have a complete annual MDS and it was late. On 12/5/24 at 8:00 AM, the Administrator reported the transition with the receivership happened on 11/4/24. She stated prior to 11/4/24 they had a Corporate MDS Coordinator that completed the MDS'. She stated after the transition, everything fell on the DON. She stated the DON and herself didn't know the scheduling and completion of the MDS' became the building's responsibility. She stated the DON completed the MDS if she noticed a late or not completed assessment. She stated since the transition on 11/4/24 there has been a lull and everyone waited to hear what is going on. She stated the DON worked as a charge nurse on the floor. She stated recently the facility hired a CMA to work full time Monday through Friday to give the DON time to complete other job duties. The Long Term Care Facility Resident Assessment Instrument 3.0 User's manual dated October 2023 directed to complete an MDS Admission Assessment not later than the 14th calendar day of the resident's admission (admitted plus 13 calendar days). The RAI manual directed to complete a comprehensive annual assessment no later than the ARD plus 14 calendar days. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Comprehensive Assessment revised August 2022 instructed to complete a comprehensive assessment of a resident's needs within fourteen days of the resident's admission. In addition, the policy listed the Assessment Coordinator as responsible for ensuring that the Interdisciplinary Assessment Team conducted timely resident assessments and reviews according to the following schedule: a. Within fourteen days of the resident's admission to the facility b. When there has been a significant change in a resident's condition c. At least quarterly; and d. Once every twelve months.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 49056 Based on record review, the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual, and staff interview, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment no less than 3 months after the last assessment for 1 of 3 residents reviewed (Resident #17). The facility reported a census of 15 residents. Findings include: The review of Resident #17's electronic health record (EHR) on 12/4/24 showed a quarterly MDS completed on 8/17/24. Resident #17's record lacked a quarterly MDS assessment after that date. Review of the facility provided policy named Comprehensive assessment dated effective October 2024 listed the Assessment Coordinator as responsible for ensuring that the Interdisciplinary Assessment Team conducted timely resident assessments and reviews according to the following schedule: a. Within fourteen days of the resident's admission to the facility b. When a resident had a significant change in their condition c. At least quarterly; and d. Once every twelve months. On 12/5/24 at 11:30 AM the Director of Nursing (DON) stated when the facility offered her the DON position, the role didn't include MDS', as at the time, the facility had someone from corporate doing them. The DON revealed she worked the floor routinely and did what she could to complete the MDS assessments. The DON reported the facility received approval to utilize agency staff. The DON explained they would set up a meeting with the other facility staff to discuss and distinguish the roles of who is responsible for completing the MDS. The Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual Version 1.19.1 reviewed October 2024 directed the time frame to complete an assessment as the assessment reference date (ARD - item A2300) must be set within 366 days after the ARD of the previous OBRA (cms required assessment) comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (the framework for structuring information) (ARD of previous OBRA Quarterly assessment + 92 calendar days).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interview, and policy review the facility failed to accurately code hospice level of care and an antipsychotic medication on the Minimum Data Set (MDS) assessment for 1 of 8 residents reviewed (Resident #15). The facility reported a census of 15 residents. Findings include: Resident #15's Clinical Census reflected an admission to hospice level of care on 6/27/24, with no change in his level of care. Resident #15's July 2024 Medication Administration Record (MAR) indicated the provider discontinued the Risperdal (antipsychotic) medication on 7/27/24. Resident #15's September 2024 MAR reflected Resident #15 didn't receive Risperdal medication during the 7-day lookback period. Resident #15's MDS assessment dated [DATE] lacked documentation that they received hospice level of care while a resident at the facility. The MDS reflected Resident #15 took an antipsychotic medication during the lookback period. On 12/5/24 at 11:25 AM, the DON (Director of Nursing) acknowledged Resident #15's MDS didn't get coded correctly related to hospice and the antipsychotic medication. She reported she would do a modification on the MDS. On 12/5/24 at 12:00 PM, the DON reported she completed the modification on Resident #15's quarterly MDS. A facility policy titled Comprehensive Assessment revised August 2022 instructed to complete an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess the relevant care areas and care knowledgeable about the resident's status, needs, strengths, and areas of decline.

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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** 49056 Based on record review, observations and staff interviews the facility failed to obtain a physician's order to apply Ready Wraps (specialized wraps to manage edema) to a resident for 1 of 1 resident reviewed (Resident #10). Resident #10 went to the Lymphedema Clinic who gave instructions to use the Ready Wraps from an Occupational Therapist (OT). The facility failed to contact the physician to ensure they had a physician order to use the Ready Wraps. The facility reported a census of 15 residents. Findings include: Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #10 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort.) with upper and lower body dressing. The MDS included diagnoses of hypertension (high blood pressure), renal insufficiency (impaired kidney function), diabetes mellitus, anxiety and depression. Resident #10's October 2024, November 2024, and December 2024 Treatment Administration Records (TAR) lacked an order to apply Ready Wraps in the morning and remove at night. Interview on 12/2/24 at 2:35 PM with Resident #10 stated she is supposed to have her wraps on daily. Resident #10 stated when she got up, the staff told her she had an appointment to go to so they didn't get put on. On 12/3/24 at 12:00 PM observed Resident #10 didn't have wraps applied to her legs. Resident #10 stated they wanted her to come out for lunch. Resident #10 stated she can't put them on herself so the staff need to assist her. The Lymphedema Center Flow Sheet dated 10/11/24 included instruction for Resident #10 to wear knee high Ready Wraps during the day and remove them at night. The Occupational Therapist documented Resident #10 needed the new garments received at her appointment for proper fit and edema management. The center sent the facility instructions regarding the use of the Ready Wraps. Interview on 12/5/24 at 11:30 AM the DON stated Resident #10 is to wear the Ready Wraps daily. The DON stated they are thigh high and it took the assist of two staff members to adjust the top of them because Resident #10 had larger thighs. The DON stated it took 5 to 10 minutes to apply them. The DON said she didn't wear them that week because she didn't feel well enough to stand up to have the staff put them on. The DON stated she thought they were on the TAR and the Care Plan, she stated she would add them. An electronic message received from the Administrator on 12/8/24 at 1:06 PM indicated the facility didn't have an order put on Resident #10's Ready Wraps. The information from the Lymphedema clinic directed for her to put on and take off independently. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Physician's orders revised October 2023 documented it was the standard of the facility that the resident's attending physician or designee orders all medication and treatment protocols. A facility policy titled Processing of Medical Orders revised October 2023 documented all Physician's orders will be appropriately transcribed and noted by a licensed nurse.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to have a discharge planning process for 1 resident who discharged (Resident #6). The facility reported a census of 15 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. The MDS included diagnoses of non traumatic brain dysfunction, hemiplegia (paralysis or weakness on one side of the body) of the non dominant side, stroke, non Alzheimer's dementia, Parkinson's and a seizure disorder. The resident's profile page identified a sibling as Resident #6's contact. Neither the Baseline Care Plan dated 9/18/24 or the Care Plan in effect at the time of discharge included discharge planning. The Progress Notes dated 10/7/24 at 10:12 AM documented a call placed to the spouse regarding a message left for the Director of Nursing (DON) regarding transferring Resident #6 closer to where she resided. At the time of conversation, they didn't have an idea of what facility would take Resident #6. Referrals can be made with spouse's permission. The clinical record lacked information about Resident #6's wish to transfer. The Progress Notes dated 11/18/24 at 10:31 AM reflected Resident #6's primary care provider knew of their discharge, the facility awaited signed orders. On 11/18/24 at 5:09 PM Resident #6 discharged to another nursing facility, took all their belongings, and rode in a staff member's personal vehicle. All signed paperwork sent with Resident #6. The clinical record lacked a copy of the transfer form for the other facility, and lacked documentation Resident #6's contact participated in the discharge planning. An email from the DON on 12/4/24 at 1:16 PM reflected Resident #6 transferred to another area. He had a BIMS score of 14, confirming he had the intellectual sound mind to make his own decisions. He originally requested to go to a facility where his wife resided. Upon speaking to his wife, she okayed a request to send a referral to that facility. However, the facility failed to return phone calls regarding the transfer. Along with sending the referral to that facility, they sent several other facilities referrals. On 12/4/24 at 2:42 PM the Administrator stated the resident had a high BIMS and wanted to move closer to friends. She thought they had the fax they sent to the other facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Discharge Summary and Plan revised November 2017 documented the discharge plan, with its focus on resident's goals was designed to provide for an effective transition to post discharge care, enable the resident to be an active partner in their discharge. When the facility anticipates the resident's discharge to a private residence or another care facility a discharge summary and post discharge plan would be developed which would assist the resident to adjust to his/her new living environment.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to ensure a recapitulation for 1 resident who discharged (Resident #6). The facility reported a census of 15 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. The MDS included diagnoses of non-traumatic brain dysfunction, hemiplegia (paralysis or weakness on one side of the body) of the non-dominant side, stroke, non-Alzheimer's dementia, Parkinson's and a seizure disorder. The Progress Note dated 11/18/24 at 5:09 PM documented Resident #6 discharged to another nursing facility, took all their belongings, and rode in a staff member's personal vehicle. All signed paperwork sent with resident. The clinical record lacked a recapitulation of Resident #6's stay at the facility. On 12/4/24 at 2:42 PM the Administrator stated Resident #6 had a high BIMS and wanted to move closer to friends. The facility policy, Discharge Summary and Plan revised November 2017 documented when the facility anticipated the resident's discharge to a private residence or another care facility, a discharge summary and post discharge plan would be developed which would assist the resident to adjust to his/her new living environment. The discharge summary would include a recapitulation of the resident's stay at the facility.

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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 review, staff interviews, wound center records, wound center interviews, and facility policy review the facility failed to provide interventions necessary for the care and services, to maintain the residents' highest practical physical well being for 1 of 2 resident reviewed (Resident #3) for skin treatments. The facility failed to complete and document treatments of Resident #3's right posterior lower leg wound. The facility reported a census of 15 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. The MDS identified Resident #3 as dependent on staff for bed mobility, transfers, and toileting. The MDS included diagnoses of hypertension (high blood pressure), septicemia (life threatening infection in the bloodstream), cerebrovascular accident (CVA or stroke), right sided hemiplegia (paralysis or weakness affecting one side of the body), seizure disorder, traumatic brain injury (TBI), malnutrition (inadequate nutritional intake), and cellulitis (skin infection) of the right lower limb. The MDS identified Resident #3 had one venous ulcer (open skin sore caused by problems with blood flow in the legs) present. The MDS indicated the facility provided a turning/repositioning program, nutrition interventions, hydration interventions, application of nonsurgical dressing, and applications of ointments/medication other than to their feet. The Care Plan Focus with a target date of 12/18/24 indicated Resident #3 had a potential for skin impairments. 6/8/24 Resident #3 had a venous stasis ulcer to his right post lower leg that had reoccurred for year. The Wound Center previously treated the area. The Interventions directed staff to complete treatments as ordered. A Progress Note dated 9/3/24 identified Resident #3 admitted to the hospital for sepsis of an unknown etiology (cause). A Progress Note dated 9/9/24 reflected Resident #3 readmitted to the facility. A Progress Note dated 9/11/24 indicated Resident #3 had a stage 2 pressure (partial thickness loss of skin) wound to her right posterior leg with purulent drainage (thick, milky, pus containing fluid). The note lacked documentation of size or measurements. A Progress Note dated 9/18/24 documented Resident #3 continued to have a stage 2 pressure wound to the right poster leg with purulent drainage. The note lacked documentation of size or measurement. A Progress Note dated 9/19/24 at 2:45 PM documented Resident #3 went to an appointment at the wound center. A Progress Note dated 9/19/24 at 4:47 PM documented Resident #3 returned from the wound center with new orders for dressing changes to bilateral lower extremities three times a week on Tuesday, Thursday, and Saturday. The note instructed Resident #3 to return to the wound center for their next appointment on 9/26/24 at 1:00 PM. (continued on next page)

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	165344	A. Building B. Wing	12/05/2024

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Wound Center Progress Report dated 9/19/24 documented Resident #3 had a right posterior lower leg wound, with primary venous and secondary pressure etiology, measured 5.7 cm (centimeters)(length) x 2.9 cm (width) x 0.2 cm (depth). It had moderate purulent drainage (yellow, brown, green), granulation tissue, and necrotic tissue (dead/nonviable tissue). Excisional debridement (procedure to remove damaged, dead or infected tissue) was performed. Staff were instructed to cleanse the wound with saline, apply Aquacel AG ribbon (dressing that absorbs fluid), and cover it with Mepilex Border (foam dressing) 3 times a week. Resident #3 was directed to return to the wound center in one week. A Wound Center Progress Report dated 9/26/24 documented Resident #3's venous ulcer on the right posterior lower leg measured 3.2 cm x 2.3 cm x 0.3 cm. It exhibited moderate amounts of purulent drainage, granulation tissue, and necrotic tissue. Excisional debridement was performed. The discharge instructions instructed staff to clean the wound with normal saline, cut Aquacel AG ribbon to the appropriate size, apply it to the wound bed, cover with a Mepilex Border dressing three times a week, then return to the Wound Center in 2 weeks. The September 2024 Treatment Administration Record (TAR) and clinical record lacked documentation that staff completed the treatment to Resident #3's right posterior leg from 9/20/24 to 9/30/24. A Wound Center Progress Report dated 10/10/24 documented Resident #3's right posterior lower leg venous ulcer measured 4.4 cm x 2.6 cm x 0.5 cm, with moderate purulent drainage, small granulation, and large necrotic tissue. The clinic performed excisional debridement. The orders instructed the staff to cleanse the wound with saline, apply Aquacel AG ribbon, and cover it with Mepilex Border 3 times a week. The Wound Center ordered Resident #3 to return to the wound center in one week, with a referral to the lymphedema clinic. A Wound Center Progress Report dated 10/17/24 documented Resident #3 right posterior lower leg venous ulcer measured 6.0 cm (length) x 2.9 cm (width) x 0.5 cm (depth). The venous ulcer had moderate purulent drainage, small granulation, and large necrotic tissue. They performed excisional debridement. The Wound Center ordered the staff to clean the wound with saline, apply Aquacel AG ribbon, and cover it with Mepilex Border 3 times a week, then return for their lymphedema appointment on 10/22/24. A Wound Center Physician Progress Note dated 10/17/24 documented Resident #3's right posterior lower leg wound had some yellow slough, necrosis and was stable. The note documented the treatment plan was to start lymphedema wraps, continue with Aquacel ag, gauze and tape. Resident #3 to follow up in the wound center in one week. A Progress Note dated 10/22/24 documented Resident #3 out of the facility to lymphedema appointment and returned with a follow-up appointment. A Wound Center Progress Report dated 10/24/24 documented Resident #3's right posterior lower leg venous ulcer measured 5.5 cm x 2.5 cm x 0.5 cm, with moderate purulent drainage, small granulation, and large necrotic tissue. Excisional debridement was performed. Discharge instructions included cleansing the wound with saline, applying Aquacel AG ribbon, and covering with Mepilex Border twice a week. Resident #3 was to follow up in one week. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Wound Center Physician Progress Note dated 10/24/24 indicated the right posterior lower leg wound showed yellow slough, necrosis, and remained stable. The treatment plan included lymphedema wraps twice a week, along with Aquacel AG, gauze, and tape. Resident #3 was to follow up at the wound center in one week. A Progress Note dated 10/31/24 documented transportation refused to transport Resident #3 to his appointments due to behavioral issues on the last date of appointments. The October 2024 TAR and clinical record lacked documentation that staff completed the treatment to Resident #3's right posterior leg from 10/1/24 to the start of lymphedema therapy on 10/22/24. Review of Progress Notes from 10/31/24 to 11/19/24 lacked documentation that Resident #3 had any further wound center or lymphedema appointments. The clinical record lacked any follow up or documentation regarding a wound treatment to the right posterior lower leg until 11/19/24. The November 2024 TAR from 11/1/24 to 11/19/24 lacked documentation of the staff completing the treatment to Resident #3's right posterior lower leg. A Progress Note on 11/19/24 documented the facility called the wound center for order or recommendations for treatment. A Physician Order dated 11/19/24 directed staff to apply Aquacel ag to wound bed, cover with border foam dressing, apply sensi sock and tubi grip over top. The Physician order lacked direction on how to cleanse the wound and where to apply the dressing. The November 2024 TAR included an order with a start date of 11/20/24 directing staff to cleanse bilateral leg wounds with normal saline, cut Aquacel ag ribbon to size, apply to wound, cover with border foam dressing. Apply sensi socks and place tubi grip over sock every day shift every Monday, Wednesday and Friday for wound care. The ARNP's (Advance Registered Nurse Practitioner) Progress Notes dated 11/19/24 documented Resident #3 had a history of recurrent wounds on his lower extremities. The note documented Resident #3 went to the wound center but now no one would drive him because he of his verbal abusive to his driver. The note documented the DON (Director of Nursing) monitored Resident #3's wound care. The note documented the facility received orders from the wound center to continue the current treatment plan and used an Aquacel dressing under a border. The patient was to wear a tubi stocking and sensi socks. On 12/4/24 at 12:55 PM, observed Resident #3 in the hallway with sensi socks in place without a tubigrip over the right sock as the physician ordered. On 12/4/24 at 3:00 PM, the DON reported that Resident #3 treatments were completed at the lymphedema or wound center until recently. She stated the facility wasn't able to secure transportation for Resident #3 due to his behavior. She stated the transport companies refused to take Resident #3 and his sisters couldn't take him to his appointments. She stated the facility started doing his treatments in house when they obtained a physician order on 11/19/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/4/24 at 4:00 PM, the Wound Center RN (Registered Nurse) reported they saw Resident #3 at the wound center but the facility couldn't get him there, so they had to discharge him. The Wound Center RN reported the facility was supposed to be doing treatments at the facility per physician orders. The Wound Center RN reported at each visit they would send signed orders with return appointments. The Wound Center RN reported they saw Resident #3 on 8/13/24, 8/22/24, 8/29/24, 9/19/24, 9/26/24, 10/10/24, 10/17/24, and 10/24/24. She stated the wound center collaborated with the lymphedema center. She stated Resident #3 only went to the lymphedema center twice according to her knowledge before they stopped seeing him. She stated Resident #3 had a traumatic brain injury, would get upset, frustrated, and refused care at times. She stated his wound got worse over time and she attributed the decline to his co morbidities and lack of care. She stated he was never hospitalized or had sepsis from the wound. On 12/5/24 at 7:45 AM, the DON reported she reviewed the wound center documentation and verified the TAR or Medication Administration Record (MAR) didn't include the treatments for his right posterior leg. She stated if it wasn't documented then it was not done. A facility policy titled Physician's orders revised October 2023 documented it was the standard of the facility that the resident's attending physician or designee orders all medication and treatment protocols. A facility policy titled Processing of Medical Orders revised October 2023 documented all Physician's orders will be appropriately transcribed and noted by a licensed nurse.

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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** 46875 Based on clinical record reviews, observations, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accidents and incidents for 2 of 2 residents reviewed (Residents #3 and #9). The facility failed to identify trends with root cause analysis and put effective interventions in place to prevent falls. In addition, they failed to provide adequate supervision to prevent resident to resident altercations. The facility reported a census of 15 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. The MDS identified Resident #3 as dependent on staff for bed mobility, transfers, and toileting. The MDS included diagnoses of hypertension (high blood pressure), septicemia (life threatening infection in the bloodstream), cerebrovascular accident (CVA or stroke), right sided hemiplegia (paralysis or weakness affecting one side of the body), seizure disorder, traumatic brain injury (TBI), malnutrition (inadequate nutritional intake), and cellulitis (skin infection) of the right lower limb. The MDS reflected Resident #3 had one fall without injury. The Facility Incident Reports (IR) from [DATE] [DATE] reflected Resident #3 fell on [DATE], [DATE], and [DATE]. The Care Plan Focus with a target date of [DATE] indicated Resident #3 had a moderate risk for falls related to their right sided hemiplegia. The interventions directed the following: a. [DATE]: If fall occurred, initiate frequent neurological and bleeding evaluation per facility protocol b. [DATE]: If resident had a risk for falls, initiate fall risk precautions c. [DATE]: Be sure to have Resident #3's call light within his reach and encourage him to use it for assistance as needed. Provide prompt response to all requests for assistance d. [DATE]: Follow facility fall protocol e. [DATE]: Directed Resident #3 to ask for help/call light use for assistance to pick up items on floor. An IR dated [DATE] at 7:45 PM indicated staff found Resident #3 on the floor in his room laying on his back all stretched out. He had his head near the door with his feet toward the bed. Resident #3 tried to get something and fell out of his wheelchair. The identified Resident #3 as incontinent and angry with staff and peers when he returned from his smoking break. The IR documented the staff notified the Administrator, Director of Nursing (DON), and physician of his fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IR lacked family notification or an intervention. An IR dated [DATE] at 1:45 PM reflected the staff heard Resident #3 repeatedly yelling help. When the nurse walked down to his room, they observed Resident #3 laying on the floor on his right side. He laid near the door to his room, with his wheelchair pushed back toward his roommate's side of the room behind the door. Resident #3 reported his hat fell on the floor, as he attempted to bend over to reach it by himself, his wheelchair slipped out from under him, causing him to fall to the floor. The IR identified the facility notified the DON, physician and family member of Resident #3's fall. The staff instructed Resident #3 to use the call light to ask for assistance rather than reaching for things on the floor by himself. A facility form titled Root Cause Analysis Tool dated [DATE] documented the results of the investigation was Resident #3 attempted to pick up an item off the floor without asking for help. The corrective action indicated they educated Resident #3 to ask for help and use the call light to ask for help picking up items off the floor. An IR dated [DATE] at 2:15 PM documented staff heard Resident #3 yelling for help from his room. The staff observed Resident #3 on the floor on his left side in front of the bathroom door with his wheelchair behind him. Resident #3 explained he tried to pick something up off the floor when he slid out of the wheelchair. The facility educated Resident #3 on the importance of not leaning forward to pick up anything off the floor. The incident report and clinical record lacked documentation of notification to Resident #3's physician or his family of the fall. The progress notes in the clinical record lacked documentation regarding the fall. A facility form titled Root Cause Analysis Tool dated [DATE] identified Resident #3 fell be he tried to pick up an item off the floor of the bedroom. The corrective action listed the facility reminded Resident #3 to ask for help. On [DATE] at 9:19 AM, the DON (Director of Nursing) acknowledged she couldn't locate an intervention for Resident #3's fall on [DATE] or documentation that someone notified Resident #3's family of the fall. On [DATE] at 9:19 AM, the DON verified no one notified Resident #3's physician and family of fall on [DATE]. The DON verified the clinical record didn't include documentation of Resident #3's fall on [DATE] or an intervention implemented after the fall. The DON reported the agency nurse didn't complete all the steps required when Resident #3 fell on [DATE]. On [DATE] at 10:50 AM, the DON reported she expected the following steps to be completed when a fall occurred: - Risk Management Assessment (incident report) - Neurological Assessment with unwitnessed fall even if there is no evidence the resident hit their head - Notify the Physician and family (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Implement a new intervention and update the Care Plan - Document the fall in the progress notes - Completed required assessments which include post fall assessment, pain assessment and skin assessment if there were any new skin areas related to the fall. On [DATE] at 11:30 AM, the DON acknowledged Resident #3 had a trend with falling as he tried to reach for items while in his wheelchair. In addition, she acknowledged Resident #3 had a low BIMs score of a 1 that indicated he had severe cognitive impairments. When asked if she felt the intervention for Resident #3 to remember to use his call light or call for staff assistance was effective, she reported she felt Resident #3 could communicate his needs. She added she felt he fell due to his behaviors and wanting to be independent. The facility policy titled Assessing Falls and Their Causes Guidelines revised [DATE] provided guidelines for assessing a resident after a fall and identifying its causes. It required nursing staff to notify the resident's Attending Physician and family within an appropriate timeframe. Within 24 hours of a fall, staff must begin investigating potential causes, documenting any identified factors. The policy specified that the following information must be recorded in the resident's medical record: a. the resident's condition when found b. assessment data including vital signs and injuries c. interventions or treatment given d. notification of the physician and family d. completion of a falls risk assessment and e. measures to prevent future falls. 49056 2. Resident #9's MDS assessment dated [DATE] identified the facility didn't complete a BIMS due to them being rarely/never understood. The Staff assessment of cognition patterns identified Resident #9 had short and long-term memory problems, he could normally recall the location of his own room. He had severely impaired decision-making abilities. He had physical and verbal behaviors for 1 to 3 days in the lookback period with other behavioral symptoms daily. He rejected care 1 to 3 days in the lookback period. The MDS included diagnoses of non Alzheimer's dementia, seizure disorder, anxiety disorder, bipolar disorder, and intermittent explosive disorder. The Care Plan Focus with a target date of [DATE] indicated Resident #9 required behavior management. The interventions instructed the following: a. Attempt an alternate time to provide care refused, per Resident's preference b. Educate Resident #3 or their Representative on the necessity of care attempted to provide. c. Ensure the safety of Resident #9 and others (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Establish boundaries and limits with Resident #9 e. Initiate visual supervision during acute episode f. Monitor for emotional factors that may contribute to new behavior g. Monitor for environmental factors that may contribute to new behavior h. Provide emotional support regarding new onset of repetitive behaviors i. Provide verbal feedback to Resident #9 regarding behavior j. Utilize diversion techniques as needed The Care Plan Focus with a target date of [DATE] identified Resident #9 had a history of physical aggressive related to a history of harm to others. Resident #9 bit a staff member during care on [DATE] and [DATE]. Resident #9 had a resident to resident altercation on [DATE]. The interventions directed the following: a. Administer medications as ordered. b. Monitor/document for side effects and effectiveness. c. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning and pain. d. Monitor, document, and report as needed any signs or symptoms of Resident #9 posing a danger to self and others. e. Psychiatry/Psychogeriatric (Psychiatrist that specializes in older age mental health) consult as indicated. f. When Resident #9 becomes agitated: i. Intervene before agitation escalates ii. Guide away from source of distress iii. Engage calmly in conversation iv. If response is aggressive, after ensuring his safety, staff to walk calmly away, and approach later. On [DATE] at 2:15 PM observed Resident #9 sitting in the entry way of the dining room. Resident #9 reached over and pulled Resident #3's headphones off his head when he entered the dining room. Observed the staff intervene after Resident #3 yelled you son of a bitch. The Administrator came over and separated the two residents. When the staff intervened Resident #9 grabbed what looked like a piece of cloth from his coat/arm. The staff intervened and separated residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:30 PM witnessed Resident #9 in his wheelchair at the beginning of the east hallway turning the light switch on and off. On [DATE] at 2:45 PM saw Resident #9 by the nurses' station in his wheelchair, he turned on and off the lights in the east hallway. Heard Resident #7 yell at Resident #9, Don't you try and kick me, you son of a bitch. Saw Resident #9 walking away from Resident #7 toward her room. Witnessed staff members present at the nurses' station when the incident occurred. On [DATE] at 11:20 AM watched the residents enter the dining room. As Resident #15 sat at the dining room table, at 11:39 AM Resident # 9 wheeled himself up to the dining room table beside them. While observing the room, heard Resident # 15 said don't do that. Noted Resident # 9 putting his fingers in her face. Resident #9 had his large handled spoon in his hand jabbing toward Resident #15's face. When Resident #15 yelled for help, the Administrator responded and they told her what happened. The Administrator removed Resident #9 from that part of the table. Then staff stayed in the dining room for monitoring. The Health Status Note dated [DATE] at 3:33 PM, indicated Resident #9 had aggressive behaviors towards other residents. The facility requested the physician to restart Resident #9's expired Haldol, haloperidol (antipsychotic medication). The physician responded okay to initiate the as needed (PRN) order for haloperidol 2 milligrams (mg) every twelve hours. The emergency kit included documentation of four 0.5 mg tablets of haloperidol removed. The facility's Accidents policy, effective [DATE], focused on minimizing accident hazards through a combination of environmental safety measures and individual resident risk assessments. The policy emphasized resident supervision, which is tailored to each resident's needs and environmental risks. Supervision may be adjusted based on factors like temporary hazards or changes in the resident's condition. Safety and accident prevention are top priorities, and supervision levels are reassessed based on behaviors such as aggression, restlessness, or inappropriate actions. The policy also encouraged addressing underlying causes of disruptive behaviors and ensuring appropriate supervision protocols.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on facility record review, staff interviews and the facility policy, the facility failed to properly handle the destruction of medications according to the standards of practice for 1 of 15 residents reviewed (Resident #9). The facility reported a census of 15 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified the facility didn't complete a Brief Interview for Mental Status (BIMS) due to them being rarely/never understood. The Staff assessment of cognition patterns identified Resident #9 had short and long-term memory problems, he could normally recall the location of his own room. He had severely impaired decision-making abilities. He had physical and verbal behaviors for 1 to 3 days in the lookback period with other behavioral symptoms daily. He rejected care 1 to 3 days in the lookback period. The MDS included diagnoses of non-Alzheimer's dementia, seizure disorder, anxiety disorder, bipolar disorder, and intermittent explosive disorder. On 12/4/24 at 11:00 AM the Administrator and the Director of Nursing (DON) reported that during a facility investigation regarding the medication Depakote (antiseizure medication), revealed they contacted the facility pharmacy to ask questions regarding the amount of medication they sent to the facility and the amount the facility returned to the pharmacy. The Administrator revealed they didn't have a record of the medications being returned, except 35 tablets of the Depakote. The Administrator stated Staff B admitted she tore the top off the bubble pack, punched out the remaining medications, and threw the bubble pack away. The Administrator stated she would put the medication she punched out in the drug buster. The Administrator stated she educated the nurses during a meeting with them. On 12/4/24 at 4:26 PM the DON reported the nurses didn't document what they destroyed in the drug buster. The DON stated they document the destruction of the narcotics on the narcotic sheet and have 2 nurses sign. On 12/4/24 at 5:53 PM Staff B, Registered Nurse (RN), explained at the end of the month for medication changeover she tore the name off the bubble pack, shredded it, punched out the medication left over, and threw the bubble pack away. Staff B stated she destroyed the leftover medication in the drug buster in the medication room. Staff B stated she usually knew why the bubble pack still had medication due to working so many hours. Staff B explained if the resident refused the medication or got admitted to the hospital. Staff B stated she denied knowing she had to send the medication back to the pharmacy. The facility policy named Discarding and Destroying Medications effective October 2024 instructed to destroy medications that can't return to the dispensing pharmacy as permitted by stated regulations. Whoever witnessed the destruction/disposal of medications must sign and date the medication disposition record. The medication disposition record must contain, at a minimum the following information: a. The resident's name (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The date medication destroyed c. The name/strength of the medication d. The prescription number, if known e. The name of the dispensing pharmacy f. The quantity destroyed g. The method of destruction h. Reason for destruction i. Signature of witnesses. Unless otherwise prohibited under applicable federal or state laws, individual resident medications supplied in sealed unopened containers may be returned to the issuing pharmacy. The receiving pharmacist and a nurse employed by the facility sign a separate log that listed the resident's name; the name, strength, prescription number (if applicable) and amount of the medication returned, and the date the medication was returned. Completed medication disposition records shall be kept on file in the facility for at least two years or as mandated by state law governing the retention and storage of such records.

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Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, staff interview and facility policy review, the facility failed to provide an appropriate clinical rationale for a gradual dose reduction (GDR) declination for 1 out of 1 resident reviewed (Resident #12) for unnecessary medications. The facility reported a census of 15 residents. Findings include: Resident #12's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of a dash with a dash for the staff assessment for cognitive patterns, indicating the facility didn't complete the assessment. The MDS included diagnoses of anxiety, depression, diabetes mellitus, and renal insufficiency. MDS reflected Resident #12 received an antidepressant and antipsychotic medication during lookback period. The Clinical Physicians Orders reviewed on 12/5/24 included the following orders: a. Dated 12/21/23: Quetiapine fumarate (antipsychotic) 25 milligrams (mg) by mouth every night. b. Dated 3/13/24: Sertraline (antidepressant) 150 mg by mouth daily. A facility form named Consultation Report dated 10/15/24 regarding a gradual dose reduction (GDR) request for Resident #12's quetiapine identified an incomplete form. The Psychiatric Subsequent assessment dated [DATE] lacked documentation related to the clinical rationale related to the continued use of quetiapine and sertraline. On 12/3/24 at 11:45 AM the Director of Nursing (DON) stated the physician addressed the GDR's in her progress notes or the Psychiatric Subsequent Assessment. The review of the Psychiatric Subsequent assessment dated [DATE] directed to continue medications. The facility's Medication Regimen Reviews policy effective April 2024 required the consultant pharmacist to review medication regimens following state and federal guidelines. For psychotropic drugs, the review must include: documentation of a specific diagnosis, the need for gradual dose reductions, and behavioral interventions unless contraindicated. As-needed psychotropic medications should be limited to 14 days, with documentation required for any extension. The attending physician or nurse practitioner must justify the continued use of these medications. Psychotropic drugs are not prescribed to residents who haven't used them unless necessary for a diagnosed condition.

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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** 49056 Based on clinical record review, observations, and staff interviews revealed the facility failed to document non-medical interventions prior to administering an as needed antipsychotic for 1 of 1 resident (Resident #9). The facility reported a census of 15 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified the facility didn't complete a Brief Interview for Mental Status (BIMS) due to them being rarely/never understood. The Staff assessment of cognition patterns identified Resident #9 had short and long-term memory problems, he could normally recall the location of his own room. He had severely impaired decision-making abilities. He had physical and verbal behaviors for 1 to 3 days in the lookback period with other behavioral symptoms daily. He rejected care 1 to 3 days in the lookback period. The MDS included diagnoses of non-Alzheimer's dementia, seizure disorder, anxiety disorder, bipolar disorder, and intermittent explosive disorder. On [DATE] at 2:15 PM observed Resident #9 sitting in the entry way of the dining room. Resident #9 reached over and pulled Resident #3's headphones off his head when he entered the dining room. Observed the staff intervene after Resident #3 yelled you son of a bitch. The Administrator came over and separated the two residents. When the staff intervened Resident #9 grabbed what looked like a piece of cloth from his coat/arm. The staff intervened and separated residents. On [DATE] at 2:30 PM witnessed Resident #9 in his wheelchair at the beginning of the east hallway turning the light switch on and off. On [DATE] at 2:45 PM saw Resident #9 by the nurses' station in his wheelchair, he turned on and off the lights in the east hallway. Heard Resident #7 yell at Resident #9, Don't you try and kick me, you son of a bitch. Saw Resident #9 walking away from Resident #7 toward her room. Witnessed staff members present at the nurses' station when the incident occurred. On [DATE] at 11:20 AM watched the residents enter the dining room. As Resident #15 sat at the dining room table, at 11:39 AM Resident # 9 wheeled himself up to the dining room table beside them. While observing the room, heard Resident # 15 said don't do that. Noted Resident # 9 putting his fingers in her face. Resident #9 had his large handled spoon in his hand jabbing toward Resident #15's face. When Resident #15 yelled for help, the Administrator responded and they told her what happened. The Administrator removed Resident #9 from that part of the table. Then staff stayed in the dining room for monitoring. The Health Status Note dated [DATE] at 3:33 PM, indicated Resident #9 had aggressive behaviors towards other residents. The facility requested the physician to restart Resident #9's expired Haldol, haloperidol (antipsychotic medication). The physician responded okay to initiate the as needed (PRN) order for haloperidol 2 milligrams (mg) every twelve hours. The emergency kit included documentation of four 0.5 mg tablets of haloperidol removed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress notes lacked documentation of non-medicinal interventions before administering the PRN medication. In addition, the progress notes lacked documentation of adverse drug reactions, side effects, or effectiveness of the haloperidol. Resident #9's [DATE] Treatment Administration Record (TAR) lacked documentation of aggressive behaviors or any behavioral interventions attempted for [DATE]. The Point of Care Response History related to Behavior Monitoring & Interventions reviewed on [DATE] included documentation for [DATE] indicated Resident #9 didn't have behaviors on [DATE]. On [DATE] at 11:00 AM the DON reported they provide non-medical interventions of offering him food and/or taking him back to his room. The DON revealed they did behavioral monitoring on him. During an interview on [DATE] at 12:45 PM with the DON acknowledged she gave Resident #9 the haloperidol.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26527 Based on observation, and staff interview, the facility failed to prepare and distribute food in accordance with professional standards for food service safety. The facility reported a census of 15 residents. Findings include: The noon menu for 12/2/24 included apple pie. On 12/2/24 at 11:25 AM watched Staff A, Cook/Dietary Aide, plate apple pie. Staff A wore gloves and touched multiple surfaces such as plates, pie pan, counter, while they plated the pie. Staff A used a pie utensil in her right hand and used her left hand to hold the pie on the utensil. During observation of the noon meal on 12/2/24, Staff A took room trays down the hallway. Staff A covered the food and fluids on the trays, except for 2 of the 3 servings of apple pie remained uncovered. On 12/3/24 at 4:01 PM the Food Service Supervisor (FSS) stated the staff should cover all foods transported down the hall to a resident's room. He said they should have covered the pie. He said if they wore gloves they could only touch the ready to eat food. If they touched another surface, they needed to change their gloves. The facility policy for Preventing Illness Employee Hygiene and Sanitary Practices revised October 2023 identified gloves as a single use item and must be discarded after completing the task for which they were used. The facility policy, Food Preparation and Service revised October 2024 directed to cover the food during transportation and distribution to residents.

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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** 49056 Based on clinical record review, observations, facility policy review, residents and staff interviews the facility failed to provide accurate documentation of medical records in accordance with acceptable professional standards and practice for 2 of 2 residents reviewed (Residents #3 and #9). The record review lacked documentation of an as needed antipsychotic medication being administered and lacked fall documentation in the progress notes. The facility reported a census of 15 residents. Findings Include: 1. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified the facility didn't complete a Brief Interview for Mental Status (BIMS) due to them being rarely/never understood. The Staff assessment of cognition patterns identified Resident #9 had short and long-term memory problems, he could normally recall the location of his own room. He had severely impaired decision-making abilities. He had physical and verbal behaviors for 1 to 3 days in the lookback period with other behavioral symptoms daily. He rejected care 1 to 3 days in the lookback period. The MDS included diagnoses of non-Alzheimer's dementia, seizure disorder, anxiety disorder, bipolar disorder, and intermittent explosive disorder. The Care Plan Focus with a target date of [DATE] identified Resident #9 used psychotropic medications related to behavior management and bipolar disorder. The interventions directed the following: a. Administer psychotropic medications as ordered by physician b. To monitor, document, and report any adverse reactions of the medications. c. Monitor for side effects and effectiveness every shift. The Health Status Note dated [DATE] at 3:33 PM, indicated Resident #9 had aggressive behaviors towards other residents. The facility requested the physician to restart Resident #9's expired Haldol, haloperidol (antipsychotic medication). The physician responded okay to initiate the as needed (PRN) order for haloperidol 2 milligrams (mg) every twelve hours. The emergency kit included documentation of four 0.5 mg tablets of haloperidol removed. Resident #9 [DATE]'s Medication Administration Record (MAR) lacked documentation of the physician order for haloperidol or that Resident #9 received the haloperidol. The progress notes lacked documentation of non-medicinal interventions before administering the PRN medication. In addition, the progress notes lacked documentation of adverse drug reactions, side effects, or effectiveness of the haloperidol. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:45 PM with the DON verified she gave Resident #9 the haloperidol. The DON acknowledged she missed the step of putting the order on the MAR, so they had a lack of follow up the days after Resident #9 received the haloperidol. The DON stated once she received the order from the physician, she emailed it to the pharmacy. The DON checked the medication cart and they received the Haldol from the pharmacy. The DON said she expected the nurse to check the order and put it on the MAR. The facility policy Physician Services dated [DATE] instructed to enter all Physician Orders for each resident into the electronic medical record immediately upon receipt. The nurse who noted the order would transcribe the order into the appropriate MAR, Treatment Administration Record (TAR), and/or other records. 46875 2. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. The MDS identified Resident #3 as dependent on staff for bed mobility, transfers, and toileting. The MDS included diagnoses of hypertension (high blood pressure), septicemia (life threatening infection in the bloodstream), cerebrovascular accident (CVA or stroke), right sided hemiplegia (paralysis or weakness affecting one side of the body), seizure disorder, traumatic brain injury (TBI), malnutrition (inadequate nutritional intake), and cellulitis (skin infection) of the right lower limb. The MDS reflected Resident #3 had one fall without injury. An IR dated [DATE] at 2:15 PM documented staff heard Resident #3 yelling for help from his room. The staff observed Resident #3 on the floor on his left side in front of the bathroom door with his wheelchair behind him. Resident #3 explained he tried to pick something up off the floor when he slid out of the wheelchair. The facility educated Resident #3 on the importance of not leaning forward to pick up anything off the floor. The incident report and clinical record lacked documentation of notification to Resident #3's physician or his family of the fall. The progress notes in the clinical record lacked documentation regarding the fall. On [DATE] at 9:19 AM, the DON verified no one documented Resident #3's fall on [DATE] in the progress notes. The DON added the agency nurse didn't complete all the steps necessary after Resident #3 fell on [DATE]. On [DATE] at 10:50 AM, the DON reported she expected the staff to document the fall in the progress notes or the clinical record. The facility policy titled Assessing Falls and Their Causes Guidelines revised [DATE] directed when a resident fell , the resident's record should include the following information: a. The condition of the resident when found. b. Assessment data, including vital signs and any obvious injuries c. Interventions, first aid, or treatment administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Notification of the physician and family, as indicated. e. Completion of a falls risk assessment. f. Appropriate interventions to prevent future falls.

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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. 46875 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 4 of 16 areas of concern. Findings include: The facility designed their QAPI Plan dated 11/27/24 to establish and maintain an organized, data-driven facility wide program utilizing a proactive approach to improve the quality of care and services throughout the facility. The QAPI Plan is a living document that will continue to be refined and revisited. It is written in accordance with the Facility's vision and mission. The objectives of the QAPI plan included the following: a. Establish a facility wide process to identify opportunities of improvement through continuous attention to quality of care, quality of life and resident safety. b. Address gaps in systems or processes c. Ensure adequate provision of staffing, time, equipment and technical training resources. d. Establish clear expectations around safety, quality, right, choice and respect; e. Continually improve the quality of care and services provided to the residents. The survey identified the following concerns during the current survey that the prior survey team cited during the surveys in the past year: a. Services provided meet professional standards. b. Free of accidents, hazards, and supervision. c. QAPI program and plan d. Food Procurement - Storage, preparation, service, and sanitation On 12/5/24 at 4 PM, the Administrator reported she acknowledged the concerns with the repeated deficiencies and concerns with QAPI. She stated she thought the facility fixed the issues. She stated they were working on getting the Director of Nursing (DON) off the floor so she would have more time to address physician orders and assist with supervision. She reported the facility had a hard time hiring nurses. She added the facility started using agency staff as of 11/15/24 and they didn't like it. She described the facility's goal as having the DON full-time in the office with her filling in as a charge nurse as needed. She stated the staff gave 100% while having big obstacles to overcome and she felt the facility made some improvements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents reviewed (Resident #3) for skin conditions. The facility reported a census of 15 residents. Finding include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. The MDS identified Resident #3 as dependent on staff for bed mobility, transfers, and toileting. The MDS included diagnoses of hypertension (high blood pressure), septicemia (life threatening infection in the bloodstream), cerebrovascular accident (CVA or stroke), right sided hemiplegia (paralysis or weakness affecting one side of the body), seizure disorder, traumatic brain injury (TBI), malnutrition (inadequate nutritional intake), and cellulitis (skin infection) of the right lower limb. The MDS identified Resident #3 had one venous ulcer (open skin sore caused by problems with blood flow in the legs) present. The MDS indicated the facility provided a turning/repositioning program, nutrition interventions, hydration interventions, application of nonsurgical dressing, and applications of ointments/medication other than to their feet. The Care Plan Focus with a target date of 12/18/24 documented Resident #3 had potential for skin impairment. The Care Plan listed Resident #3 had a recurrent venous stasis ulcer to the right posterior lower leg and saw at the wound center. The Interventions directed the staff to complete treatments as ordered. The Care Plan Focus with a target date of 12/18/24 reflected Resident #3 had enhanced barrier precautions (EBP) in place due to having open wounds. The Interventions directed the following: a. Keep signage of the EBP status on the door. b. Maintain a sufficient supply of personal protective equipment (PPE) at the entrance of the resident's room. c. Maintain a trash can for disposal of PPE inside of the room for disposal prior to exiting the room after care. d. Use PPE when providing high contact resident care activities which would include wound care or any skin opening requiring a dressing. Observations during the survey week 12/2/24 to 12/5/24 revealed no EBP sign on Resident #3's room door and PPE supplies not maintained outside of the room as directed by the Care Plan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's December 2024 Treatment Administration Record (TAR) directed staff to cleanse their bilateral leg wounds with normal saline, cut Aquacel ag ribbon to size, apply to wound, and then cover with border foam dressing. Apply sensi sock and place tubi grip over the sensi-sock every day shift on every Monday, Wednesday and Friday for wound care. On 12/4/24 at 12:55 PM, the Director of Nursing (DON) reported she would go do Resident #3's treatment to his right lower leg. Observed Resident #3 in the hallway with sensi socks to bilateral lower legs, his right lower leg didn't have a tubigrip over the sensi sock. The DON pushed Resident #3 in his wheelchair into the room referred to as the supply closet. The DON removed Resident #3's shoe and sock to his right foot and leg. She placed a plastic bag on the floor. Without completing hand hygiene, the DON put on a pair of gloves. The DON removed Resident #3's old dressing from his right lower leg and placed the dressing into the plastic sack on the floor. The old dressing had a moderate amount of green colored drainage. The DON took the wound cleanser bottle, sprayed the wound, and patted the wound with a gauze pad. The DON then applied calcium alginate to the wound bed and covered the area with a foam dressing. Without changing her gloves or completing hand hygiene, the DON applied the new dressing. The DON described the wound drainage as green with the wound edges pink in color. Without changing her gloves or completing hand hygiene, the DON applied the sensi sock, followed by tubigrip, and then put on Resident #3's shoe. After putting on the shoe, the DON removed her gloves and didn't complete hand hygiene. While completing the treatment, the DON didn't wear a gown. The DON acknowledged she didn't complete hand hygiene prior to putting on gloves and completing the treatment. She also acknowledged she wore the same pair of gloves throughout the treatment and didn't complete hand hygiene after removing the gloves. On 12/5/24 at 1:45 PM, the DON acknowledged she didn't but should have worn a gown when performing Resident #3's wound care to his right lower leg wound. She explained she had a gown out and then used it as a barrier for the supplies. The DON verified Resident #3 didn't have EBPs in place in his room. On 12/5/24 at 2:36 PM, the Administrator reported she expected the staff to follow the infection control policy, complete hand hygiene, and change gloves between dirty and clean procedures. The facility policy titled F880 Multidrug Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP) dated March 2024 directed staff to implement EBPs if the resident had a wound or indwelling medical device regardless of MDRO colonization. The policy directed enhance barrier precaution signage along with the precautions of gloves and gowns to be worn during high contact resident care activities which included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs/assisting with toileting, device care/use, feeding tube, tracheostomy, ventilator, wound care; any skin opening requiring a dressing. The facility policy titled Personal Protective Equipment Gloves F880 revised August 2009 directed staff to wash their hands after removing gloves. The facility policy titled Handwashing/ Hand Hygiene F880 revised October 2022 reflected the facility considered hand hygiene as the primary means to prevent the spread of infection. The policy directed staff to wash their hands with soap and water and/or complete hand hygiene using an alcohol-based hand sanitizer before donning sterile gloves, before and after changing a dressing, before/after handling clean or soiled dressings, and after removing gloves.