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	05/15/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, staff interviews and facility policy review the facility failed to notify the resident's representative of high-risk medication changes for 2 of 2 residents reviewed (Resident #10 and Resident #15). The facility reported a census of 15. Findings include: 1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The MDS included diagnoses of anxiety, depression, and hypertension (high blood pressure). The Health Status Note dated 12/17/24 at 10:34 AM reflected Resident #10 received a new order for quetiapine (Seroquel) 25 milligrams (mg) (antipsychotic medication), take 0.5 tablet by mouth at night. Resident #10's clinical record lacked documentation that someone notified Resident #10's Representative or received consent from them to start his new medication. 2. Resident #15's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 3, indicating severe cognitive impairment. The MDS included diagnoses of Alzheimer's Disease, hypertension, and coronary artery disease (impaired blood vessels of the heart). The Health Status Note dated 12/17/24 at 11:02 AM indicated the facility received new orders to discontinue trazadone (an antidepressant used for anxiety or sleep) 250 mg at hour of sleep (HS) and start trazadone 12. 5 mg four times a day for anxiety. Resident #15's clinical record lacked documentation that someone notified Resident #15's Representative about the change in medication. The facility provided policy named Unnecessary Medications dated April 2025 instructed residents or their representatives have the right to refuse ordered medications, also prior to initiating and increasing a medication, inform the resident, family or representative of the benefits, risks and alternatives for the mediation, in advance of such initiation or increase. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/8/25 at 11:00 AM the Director of Nursing (DON) reported they expected the staff to notify or attempt to notify the family member or representative of the resident with medication changes.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, staff interviews, and clinical record review, the facility failed to determine if a resident was capable of self-administering topical ointments/medications for 1 of 1 resident (Resident #7) reviewed. An observation of Resident #7 in his room revealed unlabeled topical ointments/medications in a plastic medication cup at his bedside for him to apply himself. The facility reported a census of 15 residents. Findings include: Resident #7's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS identified Resident #7 as independent with bed mobility, transfers and walking. Resident #7's MDS included diagnoses of cervicalgia (neck pain), dorsalgia (back pain), chronic pain, spinal stenosis (spaced inside the bone of the spine get too small) and other spondylosis radiculopathy in the lumbosacral region (age related wear of the spinal disks with compression of nerves). On 5/5/25 at 1:56 PM, observed 3 plastic medication cups containing a white cream with different amounts in each cup sitting on the bed side table. Resident #7 said the cream was for his back and he would apply it to his back when he needed it. On 5/5/25 at 2:27 PM, Staff J, LPN (Licensed Practical Nurse), went to the room with the surveyor. Staff J reported she didn't leave any topical medications/creams in Resident #7's room. Staff J reported one of the unlabeled plastic medication cups smelled like lotion. Staff J showed the surveyor of one of the plastic medication cups with a black marker label of the word elbows and the other plastic medication cup had a black marker label with the word back. Staff J reported Resident #7 received Diclofenac topical ointment (used to relieve pain and inflammation) for his back pain and Triamcinolone cream (used to treat skin conditions) to his elbows. Staff J took the 2 labeled plastic medication cups with the words elbows and back from the room. Staff J left the unlabeled cup in the room that she thought had lotion in it. Resident #7's May 2025 MAR (Medication Administration Record) included the following Physician orders for topical medications/ointments: a. 12/12/24: Triamcinolone Acetonide External Cream 0.5 % Apply to affected areas topically two times a day for a rash. b. 2/11/25: Diclofenac Sodium External Gel 1 % Apply 2 GM (grams) to lower back using a dosing device topically four times a day for pain. c. 1/7/25: Hydrocortisone External Ointment 2.5 % Apply to affected areas topically two times a day for dry, itchy skin. The Care Plan Focus with a Target Date of 5/8/25 indicated Resident #7 had a risk or actual impairment to his skin integrity due to a rash/dry skin. The Interventions directed Resident #7 preferred to self-apply cream and lotions. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's clinical records lacked a physician's order to self-administer medications or documentation of a self-administration assessment. On 5/7/25 at 9:42 AM, Staff E, LPN, reported she applied the topical medications to Resident #7 herself as it is her job. She reported she didn't know Resident #7 administered the topical medications himself . On 5/7/25 at 10:00 AM, the Director of Nursing (DON) reported Resident #7 liked to administer his creams himself at times. She reported she saw it on the Care Plan that he like to self-administer creams. The DON acknowledged Resident #7 didn't have an order to self-administer topical medications and didn't have a self-administration assessment completed. The DON reported she wouldn't expect Resident #7 to self-administer topical medications unless he had order to do so and they kept the medications in a secure place. On 5/8/25 at 10:30 AM, the DON verified she added the Care Plan intervention for self-administration of creams on 5/5/25 after the nurse brought it to her attention. A facility policy titled Self Administration of Drugs effective October 2024 instructed residents in the facility who wish to self-administer their medication may do so, if determined they are capable of doing so and clinically appropriate. The policy directed the staff and practitioner assess each resident's mental and physical abilities to determine whether a resident had the capability of self-administering medication and clinically appropriate. In addition, the staff and practitioner would perform a more specific skill assessment including the following: a. Ability to read and understand medication labels b. Comprehension of the purpose and proper dosage and administration time for his or her medications. c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them d. Ability to recognize risks and major adverse consequences of his or her medications. In addition, the policy directed the nurse staff determine who would document the medications for a resident who is able to self-administer medication. The policy included that self-administered medication must be stored in a safe and secured place, not accessible by other residents.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 complete an annual gradual dose reduction (GDR) for an antidepressant medication. The facility also failed to complete behavioral documentation and offer/attempt nonpharmacological interventions prior to increasing an antipsychotic medication for 1 of 5 residents 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 14, indicating intact cognition. The MDS identified Resident #12 as independent with bed mobility and required supervision or touch assistance with transfers and toilet use. Resident #12's MDS included diagnoses of anemia (low blood iron level), hypertension (high blood pressure), diabetes mellitus, aphasia (difficulty speaking), cerebrovascular accident (stroke) affecting the right side, anxiety disorder, depression, and bipolar disorder (a mood disorder). The MDS documented Resident #12 took antipsychotic and antidepressant medications during the 7 day lookback period. The Care Plan with a target date of 6/26/25 documented Resident #12 had diagnoses of depression, anxiety, bipolar and took psychotropic medications (antidepressant and antipsychotic). The Care Plan directed to consult with the Pharmacy and Physician to consider dosage reductions when clinically appropriate at least quarterly. The Care Plan directed staff to monitor and record occurrence of target behavior symptoms such as sadness, tearfulness, change in weight, change in sleep patterns, withdrawal, inappropriate response to verbal communication, verbal aggression towards staff/others, and document per protocol. Resident #12's April 2025 MAR (Medication Administration Record) listed the following medications: a. Duloxetine (antidepressant) 60 MG (milligrams) twice a day for major depressive disorder b. Aripiprazole (antipsychotic) 5 MG every day due to bipolar disorder. The Pharmacy Consultation Report dated 4/19/24 documented the Physician declined a GDR for Resident #12's duloxetine medication as she did well on the antidepressant medication. Resident #12's clinical record lacked documentation of a completed annual GDR for the duloxetine medication. The record reflected the last completed GDR on 4/19/24. The Behavior Note dated 4/29/25 at 10:45 AM documented Resident #12 had increased agitation and irritability. The Nurse Practitioner (NP) visited with Resident #12 and increased in aripiprazole for bipolar diagnosis was needed. A Progress Note dated 4/29/25 at 12:53 PM documented the NP was at the facility and reviewed medications with new orders to increase her aripiprazole to 5 MG daily. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #12's Behavior Monitoring and Interventions flow sheet from 4/7/25 to 5/6/25 lacked documentation of observed behaviors. Resident #12's April 2025 MAR documented no behaviors observed. Resident #12's clinical record didn't have documentation of behaviors or attempted nonpharmacological interventions prior to the increase of the antipsychotic medication on 4/29/25. On 5/6/25 at 3:15 PM, the Director of Nursing (DON) acknowledged Resident #12 clinical records lacked documentation on behaviors and non pharmacological interventions attempted prior to the increased antipsychotic medication. The DON reported she couldn't locate any other GDRs on Resident #12's duloxetine. She acknowledged they should complete the GDRs annually. A facility policy titled Unnecessary Medications effective April 2025 documented residents drug regimen will be free from unnecessary drugs. A facility policy titled Tapering Medication and Gradual Dose Reduction effective October 2024 directed to taper medications and complete gradual dose reductions in consultation with the attending physician and consultant pharmacist. The policy included to conduct them per CMS guidelines. The policy directed within the first year after a resident was admitted or started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated and after the first year, the facility shall attempt a GDR at least annually.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49056 Based on clinical record review, staff interview, facility investigation review, and policy review the facility failed to report missing money from a resident within 24 hours to the Iowa Department of Inspections, Appeals, and Licensing (DIAL) for 2 of 2 residents reviewed (Residents #2 and #8). In addition, the facility failed to report the allegation of abuse/suspected crime to the law enforcement center. The facility reported a census of 15 residents. Findings include: 1. On 5/6/25 at 4:00 PM Resident #2 asked to speak with the surveyor. Resident #2 voiced concerns that she had money stolen from her wallet, sometime in April. Resident #2 reported that she had her money in her wallet in her room and the wallet came up missing. When they found the wallet, it didn't have any money inside and she reported it to the Administrator. Resident #2 stated she had about $14.00 and some change in the wallet. On 5/6/25 the Administrator and the Director of Nursing (DON) declared they didn't know anything about Resident #2's report of missing money, but they did know about her missing wallet. They reported they found the wallet and Resident #2 only told them about the wallet missing. 2. The review of the facility's grievances revealed Resident #8 had a grievance regarding missing money. The grievance dated 1/13/25 reflected on Tuesday 1/7/25 Resident #8 had money put into her billfold and stuck in the pocket of her recliner. The wallet contained a $20, a $10, some 1's and change. On Friday 1/10/25 at 5:00 PM when Resident #8 and Staff D, Activities/Social Services, went to get her money to go to the store, the discovered the money missing. The wallet didn't have dollar bills at all, just 2 quarters. On 2/14/25 the facility provided Resident #8 with a lock box to secure the money and reimbursed her $83.00. On 5/7/25 at 11:30 AM the Administrator explained she called the corporate office and they told her to investigate, report, and replace the money. The Administrator acknowledged the facility didn't report the incident to the DIAL or to the local law department. The Administrator reported they called and reported it to the Ombudsman, who came to the facility to follow up on the incident. The Administrator stated they did an internal investigation, interviewed residents, and staff members. The Administrator added they couldn't prove someone took the money. The Administrator stated Resident #8 had money in a coin purse. She would put her hand in and out of her pocket, she went out to smoke and also to appointments. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Freedom of Abuse, Neglect and Exploitation/Abuse Prevention Standard revised May 2017 defined the purpose as to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment, and neglect of residents and the misappropriation of resident property. In addition, to review practices and omissions which if allowed to go unchecked could lead to abuse. The facility must thoroughly report, investigate, and document any complaint, allegation observation, or suspicion of resident abuse, mistreatment, or neglect whether physical, verbal, mental, sexual, involuntary, or voluntary in a uniform manner. When staff suspect a crime occurred against a resident in the facility they must report the incident to the DIAL and local law enforcement.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews and facility policy review the facility failed to offer or provide a Bed Hold notice for 1 of 2 residents reviewed (Resident #3) for discharge to the hospital. The facility reported a census of 15 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified he couldn't complete the Brief Interview for Mental Status (BIMs) exam. The facility completed the staff assessment for mental status, which listed Resident #3 as severely impaired with decision making. Resident #3's MDS included diagnoses of pneumonia, viral hepatitis (infection of the liver), wound infection, cerebrovascular accident (CVA or stroke), seizure disorder, traumatic brain injury and respiratory failure. The Clinical Census reflected Resident #3 discharged to the hospital on 2/11/25, 3/1/25, and 3/17/25. Resident #3's clinical record lacked documentation that the facility offered or provided him or Resident #3's Representative a Bed Hold notice upon discharge to the hospital. On 5/8/25 at 12:16 PM, the Administrator reported she couldn't locate Resident #3's hospitalization Bed Hold documentation. On 5/8/25 at 1:08 PM, the Administrator said she expected a bed hold to be given and obtained with each hospitalization . She said she reached out to Resident #3's sister and confirmed the bed hold had not been given. The facility policy titled Bed Hold last reviewed April 2025 instructed upon admission and when transferring a resident for a non-emergency hospitalization or for a therapeutic leave, a representative of the business office will provide information concerning the Bed Hold policy. When emergency transfers are necessary, the facility would provide the resident and the resident's representative with information concerning the bed hold policy per state law as applicable. In addition, the policy directed to file a copy of the bed hold or release record in the resident's medical record.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on record review, staff interview, and the Resident Assessment Instrument (RAI) Manual the facility failed to complete 4 of 4 residents (Residents #3, #4, #8 and #11) Minimum Data Set (MDS) entry assessments within 7 days. In addition, the facility failed to complete discharges MDS assessments within 14 days. The facility reported a census of 15 residents. Findings include: 1. Resident #4's clinical census listed a discharge to the hospital on 3/11/25 and a readmission to the facility on [DATE] from the hospital. Resident #4's clinical - MDS records reviewed 5/7/25 listed an entry MDS assessment dated [DATE] as in progress. The eMAR - Shift Level Administration Note dated 3/17/25 at 11:45 AM indicated Resident #4 returned to the facility from the hospital. 2. The eMAR - Shift Level Administration Note dated 2/17/25 at 4:20 PM indicated Resident #11 went to the emergency room . The Health Status Note dated 2/18/25 at 10:14 AM reflected the hospital admitted Resident #11. The Activity Progress Note dated 2/21/25 at 11:46 PM identified Resident #11 readmitted to the facility. Resident #11's Clinical - MDS records reviewed 5/7/25 included a Discharge Return Anticipated assessment dated [DATE] the status listed as in progress. In addition, the record included an Entry assessment dated [DATE] with a status listed as in progress. 40905 3. Interview on 5/7/25 at 2:51 PM, Resident #8 stated in December 2024 they facility transferred her to the hospital. She stayed overnight for flu like symptoms. Resident #8's Clinical Census reviewed 5/7/25 listed an unpaid hospital leave on 12/28/24 until 12/29/24. The Health Status Note dated 12/28/24 at 2:00 PM indicated Resident #8 left via ambulance at 1:40 PM to the hospital. The Health Status Note dated 12/29/24 at 5:39 PM reflected Resident #8 returned from the hospital at approximately 5:30 PM. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8's Clinical - MDS reviewed 5/7/25 reflected a Quarterly MDS on 11/7/24 and one on 2/7/25. The list lacked assessments for Resident #8's discharge and readmission related to her December 2024 hospital stay. 46875 4. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified he couldn't complete the Brief Interview for Mental Status (BIMs) exam. The facility completed the staff assessment for mental status, which listed Resident #3 as severely impaired with decision making. Resident #3's MDS included diagnoses of pneumonia, viral hepatitis (infection of the liver), wound infection, cerebrovascular accident (CVA or stroke), seizure disorder, traumatic brain injury and respiratory failure. Resident #3's Clinical Census listed the following hospitalization s: a. Hospital unpaid leave on 2/11/25 and returned on 2/14/25 b. Hospital unpaid leave on 3/1/25 and returned on 3/11/25 Resident #3's Clinical - MDS records reviewed 5/6/25 reflected a Quarterly MDS on 12/14/24 with the next assessment on 12/17/24 of a Discharge Return Anticipated. The record lacked discharge and entry assessments for the 2/11/25 - 2/14/25 or 3/1/25 - 3/11/25 hospitalization s. On 5/6/25 at 3:15 PM, the Director of Nursing (DON) acknowledged Resident #3 didn't have completed discharge and/or entry MDS assessments. She reported she learned in MDS training she didn't need to do the entry and discharge MDS for Medicaid residents unless they were out of the building more than 10 days. The Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's manual dated October 2024 instructed tracking records include a select number of MDS items and are required for all residents in the nursing home and swing bed facility. They include: o Entry Tracking Record o Death in Facility Tracking Record The Entry Tracking Record must be completed every time a resident is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility), including upon return if a resident in a Medicare Part A stay is discharged from the facility and does not resume Part A within the same facility within the 3-day interruption window (see Interrupted Stay in Section 2.5, Assessment Types and Definitions above). Must be completed within 7 days after the admission/reentry. Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days). The Discharge Assessment - Return Not Anticipated must be completed: a. when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. b. Must be completed within 14 days after the discharge date . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, staff interview, policy review, and the Resident Assessment Instrument (RAI) Manual, the facility failed to accurately code an antipsychotic and anticoagulant medication and a urinary tract infection (UTI) on the Minimum Data Set (MDS) assessment for 4 out of 15 residents reviewed (Residents #11, #13, #15, and #6). The facility reported a census of 15 residents. Findings include: 1. Resident #11's February 2025 Medication Administration Record (MAR) listed an order for apixaban (Eliquis), an anticoagulant (blood thinner). Resident #11's MDS assessment dated [DATE] lacked documentation they received an anticoagulant medication during the lookback period. 2. Resident #13's February 2025 MAR listed an order for trazodone, an antidepressant. Resident #13's MDS assessment dated [DATE] lacked documentation they received an antidepressant. The MDS reflected Resident #13 took an antipsychotic medication during the lookback period. The MDS lacked documentation Resident #13 took an antidepressant medication during the lookback period. 3. Resident #15's February 2025 MAR listed an order for clopidogrel bisulfate (Plavix), an antiplatelet (prevent platelets in the blood from sticking to get to develop a blood clot). The MAR lacked documentation Resident #15 received an anticoagulant. Resident #15's MDS assessment dated for 2/17/25 reflected they received an anticoagulant and antiplatelet medication during the lookback period. A facility policy titled Comprehensive assessment dated [DATE] 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. The Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's manual dated October 2024 instructed don't code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as an anticoagulant. On 5/7/25 at 3:00 PM the Director of Nursing (DON) acknowledged she coded the MDS's incorrectly. 40905 4. Resident #6's MDS assessment dated [DATE], reflected they received an anticoagulant (AC) (medication used to thin the blood to prevent blood clots). Resident #6's MDS lacked documentation they had a urinary tract infection during the 30 day lookback period. Resident #6's April 2025 MAR lacked an order for an AC medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6's April 2025 MAR included a physician's orders for levofloxacin (antibiotic) for a urinary tract infection (UTI) for 3/31/25 - 4/4/25 and cephalexin (antibiotic) for a UTI for 4/4/25 - 4/14/25. A facility policy titled Comprehensive Assessment effective March 2025, instructed residents will receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 revise a Care Plan for 1 of 3 residents reviewed (Residents #5) for falls. The facility reported a census of 15 residents. Findings include: Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS identified Resident #5 as independent with bed mobility, transfers and walking. Resident #5's MDS included diagnoses of hypertension (high blood pressure), anemia (low blood iron levels), fibromyalgia (a form of nerve pain), difficulty walking, unsteadiness on feet, muscle weakness and pain in the left knee. The MDS documented Resident #5 had a fall since last assessment with no injury. An Incident Report (IR) dated 1/17/25 at 12:50 PM revealed Resident #5 fell in her room. The IR documented Resident #5 reported she stood up, attempted to adjust her robe and when she went to sit back down she didn't have enough room in her area and she got tripped up between the bed, chair, and bedside table. Resident #5 reported she didn't hit her head and only slid off the edge of the chair. The IR documented immediate action as Resident #5's chair to be pulled forwards out of the small space between her bed and roommate's bed, giving her more room to move. In addition, the facility educated Resident #5 on moving slower and taking time with the transfers. A form titled Root Cause Analysis Tool dated 1/17/25 documented results of the fall investigation and interventions as one-on-one (1:1) given, encouraged Resident #5 to ask for assistance with putting or taking off her robe, and moved the chair up away from the bedside table. An IR dated 3/27/25 at 4:15 PM revealed Resident #5 fell in her room. Resident #5 reported she felt weak and her legs gave out so she lowered herself to the floor into a sitting position. The IR documented the immediate action as verbal education given to Resident #5 to ask for staff assistance when feeling weak or dizzy and they posted a paper print out in her room with reminder to call for staff. The Care Plan Focus with a target date of 6/22/25 described Resident #5 as at risk for falls, with actual falls on 1/20/25, 2/25/25, 5/2/25, and 5/4/25. Review of the Care Plan lacked documentation and updated fall interventions regarding the falls that occurred on 1/17/25 and 3/27/25. Review of the CNA (Certified Nursing Assistant) Kardex dated 5/8/25 revealed the staff didn't update the Kardex to reflect Resident #5's fall interventions from 1/17/25, 1/20/25, 3/27/25, 5/2/25 and 5/4/25. On 5/7/25 at 4:47 PM the Director of Nursing (DON) acknowledged the staff didn't update Resident #5's Care Plan on 1/17/25 and 3/27/25. She reported she expected the staff to update the Care Plan after each fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/25 at 10:20, Staff E, LPN (Licensed Practical Nurse), reported the CNA's go to the Kardex to look for Care Plan interventions. On 5/9/25 at 10:30 AM, Staff F, CNA, reported she would look at the Kardex for changes and if she had any questions she would ask the nurse. On 5/9/25 at 10:32 AM, the DON acknowledged Resident #5's didn't have an updated Kardex with her current fall interventions. A facility policy titled Comprehensive Care Plans effective March 2025 instructed assessments of residents are ongoing and Care Plans are revised as information about the resident and their condition changes.

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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 observations, staff interview, and clinical record review the facility failed to provide appropriate catheter care for 1 of 1 residents reviewed (Resident #3). The facility reported a census of 15 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified he couldn't complete the Brief Interview for Mental Status (BIMs) exam. A staff assessment for mental status was completed and revealed Resident #3 was severely impaired with decision making. Resident #3's MDS included diagnoses of pneumonia, viral hepatitis, wound infection, cerebrovascular accident (CVA), seizure disorder, traumatic brain injury and respiratory failure. The MDS documented Resident #3 had an indwelling catheter. Resident #3's Clinical Physician Orders dated 4/2/25 directed staff to change Resident #3's indwelling catheter 16 FR (French) 5 cc (cubic centimeters) as needed and monitor catheter output every shift. The orders lacked a diagnosis for the indwelling catheter. The Care Plan with a target date of 5/19/25 lacked direction on the management of the indwelling catheter (how to treat, assess, handle, and maintain) and what to monitor for while the catheter is in place. On 5/6/25 at 11:45 AM, observed Resident #3 sitting in his wheelchair at the dining room table, noted his catheter bag hanging under the wheelchair with the tubing touching the floor. On 5/6/25 at 3:20 PM, observed Resident #3 sitting in his wheelchair with a smoking apron on in the front lobby. His catheter bag hanged under the wheelchair with the tubing on the floor. On 5/6/25 at 3:15 PM, the Director of Nursing (DON) reported she expected the Care Plan to address the indwelling catheter. On 5/8/25 at 10:32 AM, the DON reported she expected the catheter tubing to be positioned off the floor and coiled inside the privacy bag. The DON reported Resident #3 returned from the hospital with the catheter and thought he would keep the catheter long term due to incontinence. She said she didn't know if Resident #3 had a diagnosis for the catheter and would need to look for it. A facility policy titled Indwelling Urinary Catheter effective May 2025 instructed if a resident entered the facility with an indwelling urinary catheter, or subsequently received one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrated the necessity of the catheter. The policy directed staff to document the reason for the use of the catheter. In addition, it instructed to keep the catheter tubing and drainage bag off the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Comprehensive Care Plans effective March 2025 reflected resident assessments are ongoing with Care Plans revised as information about the resident and the resident's condition change.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, record review, staff interviews, resident interviews and policy review, the facility failed to provide appropriate respiratory services for 3 of 3 residents reviewed (Residents #3, #7, and #11). The facility reported a census of 15 residents. Findings Include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified he couldn't complete the Brief Interview for Mental Status (BIMs) exam. A staff assessment for mental status was completed and revealed Resident #3 was severely impaired with decision making. Resident #3's MDS included diagnoses of pneumonia, viral hepatitis, wound infection, cerebrovascular accident (CVA), seizure disorder, traumatic brain injury and respiratory failure. The MDS indicated Resident #3 didn't receive oxygen therapy. A Physician order dated 9/24/24 directed staff to administer albuterol sulfate nebulization solution 0.083% 3 ML (milliliters). Inhale orally via nebulizer four times a day related to COPD (chronic obstructive pulmonary lung disease) with exacerbation (flare up that makes breathing difficult) and every 12 hours as needed for shortness of breath related to COPD. A Physician order dated 10/30/24 directed staff to administer oxygen via nasal cannula at 2 liters to keep oxygen saturation about 92% as needed. The Care Plan Focus with a target date of 5/19/25 reflected Resident #3 had a risk for ineffective airway clearance. The Care Plan directed staff to administer nebulizer treatments per order. The Care Plan lacked documentation regarding oxygen administration/therapy. Review of January to May 2025 MAR (Medication Administration Record) and TAR (Treatment Administration Record) lacked documentation regarding oxygen administration, how often to monitor Resident #3's oxygen saturation, when to change the oxygen/nebulizer mask/tubing and when to clean the air filter on the oxygen concentrator. On 5/5/25 at 10:02 AM, observed Resident #3 lying in bed and with the nebulizer machine running. The nebulizer tubing was unhooked from the machine and the nebulizer mask laid in the bed. Resident #3 held onto the nebulizer tubing dated 4/20/25. Observed Resident #3's undated oxygen cannula/tubing lay on the floor under the bed with the oxygen concentrator running and set at 2 liters. On 5/5/25 at 11:35 AM, observed Staff F, CNA (Certified Nursing Assistant), assist Resident #3 to the dining room without oxygen on. Observed oxygen concentrator shut off in Resident #3's room with the oxygen tubing hanging over the tray table, and the nebulizer mask/tubing dated 4/20/25 reconnected to the nebulizer machine and the nebulizer mask sitting on the tray table. On 5/6/26 at 11:47 AM, observed Resident #3's nebulizer mask and tubing connected to the nebulizer machine and dated 5/4/25 (Sunday). When the nebulizer tubing was observed on 5/5/25 (Monday) it was dated 4/20/25. The oxygen tubing remained not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 3:15 PM, the Director of Nursing (DON) reported she expected the staff to change the nebulizer and oxygen tubing weekly on Sundays, then documented either on the MAR or TAR. She expected the nursing staff to monitor oxygen saturation when the resident experienced shortness of breath. 2. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 11, indicating moderately impaired cognition. The MDS identified Resident #7 as independent with bed mobility, transfers and walking. Resident #7's MDS included diagnoses of hypertension (high blood pressure), kidney failure, anxiety, depression, and COPD. The MDS indicated Resident #7 didn't receive oxygen therapy. Resident #7's Medical Diagnosis tab reviewed included a diagnosis of obstructive sleep apnea (intermittent air flow blockage during sleep). A Physician order dated 12/12/24 directed staff to apply oxygen at 2 liters at HS (hour of sleep) and as needed. Staff may titrate the oxygen to maintain oxygen saturation above 90%. The Care Plan with a target date of 5/8/25 lacked documentation or direction on oxygen administration/therapy or any other respiratory services related to COPD and sleep apnea. On 5/5/25 at 2:00 PM, observed CPAP machine (continuous positive airway pressure) (treatment for sleep apnea) in Resident #7's room on the bedside table along with a jug of distilled water sitting on the floor next to the bedside table. Resident #7 reported the CPAP machine needed a new hose. He said he added water to the CPAP machine when the machine needed it. The observation lacked an oxygen concentrator in the room. Review of Resident #7's clinical record lacked a Physician order for a CPAP machine and directions on administration or maintenance/set up of the machine. Review of May 2025 MAR (Medication Administration Record) and TAR (Treatment Administration Record) lacked documentation or directions regarding the CPAP machine administration/set up and oxygen administration. The N Adv - Long Term Care Evaluation dated 4/17/25 at 2:02 PM documented Resident #7 had no signs of difficulty breathing and received oxygen via a CPAP. On 5/6/25 at 3:10 PM, Resident #7 reported he didn't wear the CPAP machine because he needed a new hose/mask as it leaked air and didn't stay on. When asked if he had an oxygen concentrator in his room, he reported he didn't wear oxygen at night. The observation lacked an oxygen concentrator in the room. On 5/7/25 at 9:45 AM, Staff E, LPN (Licensed Practical Nurse), reported she put an oxygen concentrator in Resident #7's room on the evening of 5/6/25. She reported the Director of Nursing (DON) directed her to put the concentrator in the room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 10:00 AM, the Director of Nursing (DON) reported she worked as the nurse who admitted Resident #7 to the facility and she knew he had an oxygen concentrator in the room at one time. She thought they removed the concentrator when they put the CPAP machine in the room. She acknowledged she asked the staff to put an oxygen concentrator in the room the previous evening (5/6/25). She acknowledged the clinical record lacked an active order for the CPAP machine and the progress notes indicated Resident #7 wore the CPAP at times. In addition, the DON acknowledged the Care Plan didn't include the CPAP and they didn't have directions on how to clean or maintain the machine. She reported she expected the staff to follow Physician orders related to oxygen administration and for the staff to transcribe the order to either the MAR or TAR for the nurses to document when they administer the oxygen. A facility policy titled Oxygen Administration effective October 2024 documented the purpose of the policy as to provide guidelines for safe oxygen administration. The policy directed staff to verify they had a physician's order for oxygen administration. The policy directed staff to date the pieces of equipment as appropriate. The policy directed staff to record the following in the resident's medical record: a. The date and time of the preformed procedure. b. The name and title of the individual who performed the procedure. c. The rate of oxygen flow, route, and rationale. d. The frequency and duration of the treatment. e. The reason for PRN (as needed) administration. f. All assessment data obtained before, during, and after the procedure. g. How the resident tolerated the procedure. h. If the resident refused the procedure, the reason(s) why and what intervention was provided. i. The signature and title of the person recording the data. The policy lacked direction on how often to change the oxygen/nebulizer tubing or maintain the machine. A facility policy titled CPAP/BiPAP Support effective May 2024 documented the purpose of the policy as the following: a. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplement oxygen. b. To improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. To promote resident comfort and safety. The policy directed staff to review the Physician's order to determine the oxygen concentration and flow, and the PEEP pressure for the machine. In addition, the policy directed staff to review and follow the manufacturer's instructions for the CPAP machine set up and oxygen delivery. 49056 3. Resident #11's MDS assessment dated [DATE] identified a BIMS score of 12, indicating moderately impaired cognition. The MDS included diagnoses of respiratory failure, chronic obstructive pulmonary disease (COPD) and hypertension (high blood pressure). On 5/5/25 at 11:03 AM observed oxygen at 3.5 liters and the oxygen tubing lacked a date indicating when they changed it last. Resident #11's May 2025 MAR included an order dated 5/12/24 to change oxygen tubing and bubbler every Sunday, then clean air filter on the concentrator. Interview on 5/6/25 at 2:47 PM Resident #11 stated they came and changed the tubing that day (5/6/25) and put extra tubing in the bag. Resident #11 reported the staff told him the state was coming in so they had to keep the tubing off the floor. The observation of the oxygen tubing included a date of 5/4/25.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40905 Based on observation, staff interviews, facility menu, and policy review the facility failed to follow the menu for 1 of 15 residents (Resident #6). In addition, the facility failed to have the current menu reviewed and approved by the Dietician. The facility reported a census of 15 residents. Finding include: On 5/6/25 starting at 11:25 AM, Staff H, Cook, provided lunch to Resident #6 of a ground chicken breast, green beans, apple sauce, and a roll. Staff H reported Resident #6 diet as a mechanical soft, with ground meat, he couldn't receive baked beans due to the skin on the beans. The Dietary Manager (DM) received approval to omit the baked beans as the rest of the lunch food items provided the adequate nutrients. Interview on 5/6/25 at 2PM, the DM stated he notified the Registered Dietician (RD) and received approval to change the meal from Monday (5/5/25) dinner to Tuesday (5/6/25) lunch as the facility had a special holiday meal on Monday night in place of the scheduled meal. The DM added he reviewed Resident #6's mechanical soft diet with the RD and she approved to omit the baked beans with no replacement from Resident #6's lunch meal as the menu items provided the required nutrients. The facility menu titled Spring/Summer 2025, provided by the DM, lacked the RD signature indicating approval of the menu. The Monday (5/5/25) dinner meal prepared instead on Tuesday (5/6/25) at lunch consisted of herb baked chicken, seasoned beans, seasoned carrots, wheat roll/margarine, and chilled fruit cup. Interview on 5/7/25 at 10:42 AM, the RD stated she spoke with the DM and approved the meal exchange of Monday's dinner used for Tuesday's lunch. In addition, she gave approval to omit the baked beans for Resident #6's mechanical soft diet meal on Tuesday because the rest of the meal consisted of chicken, carrots, roll, and fruit. The chicken would provide the protein and the carrots and roll would provide the carbohydrates for the meal. The RD added no one asked for approval to replace the carrots with green beans as she would have instructed the facility to also provide a potato as the green beans wouldn't fulfill the carbohydrate nutrients required for the meal. Additionally, the RD stated as she worked remotely, the facility sends her the menus, she reviews, and signs when approved. Afterwards, she sends the menus back to the Administrator (ADM) and DM but she didn't receive the current spring/summer menu yet to approve as the last menus she approved and signed was for fall/winter. The RD expected the facility to have the menus approved before using, to follow the menu, and she needed to approve any menu changes. Interview on 5/7/25 at 9:57 AM, the DM reported the ADM informed him the RD signed the menus. Interview on 5/7/25 at 3:30 PM, the ADM stated the facility just received the spring/summer menus the previous week. They provided the menus to the RD, but they haven't received them back, and waited to hear back from the RD. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Menus effective October 2024 instructed the community menus will meet the nutritional needs of the residents in accordance with established national guidelines, and will be prepared in advance, be followed, and be reviewed by the facility's RD for nutritional adequacy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on observations, staff interview, and policy review the facility failed to serve food under sanitary conditions, in order to reduce the risk of contamination and food borne illness at 1 of 1 meal served. The facility also failed to properly store, label, and use food by the expiration date. The facility reported a census of 15 residents. Findings include: Observation of meal service on [DATE] starting at 11:25 AM, Staff I, Dietary Aide, lifted the trash can lid with her right hand. Without completing hand hygiene, she proceeded with her right hand to touch the handle of a cup, fill it with water, heat the water, and added hot chocolate mix to the cup. Staff I then lifted the trash can lid again with her right hand, and then proceeded to stir the hot chocolate mix into the water with a straw she held in her right hand. Staff I continued without completing hand hygiene and with her right hand removed a scoop from inside a ,d+[DATE] full container of powdered thickener, placed 3 scoops of thickener in the cup of hot chocolate, and placed the scoop back into the container. Without completing hand hygiene, Staff I, proceeded to stir the thickener into the hot chocolate with the straw in her right hand, placed a lid on the cup with the same straw through the lid and served the cup of hot chocolate with the same straw to a resident. Observation on [DATE] at 9:30 AM revealed the following: a. The 2-door refrigerator contained 3 full gallons of white milk with the manufacturer's best by date of [DATE], a half-gallon of chocolate milk, and a half-gallon of white milk with the manufacturer's best by date of [DATE]. b. The upright freezer contained 5 BBQ pork patties in a box with the bag open, 3 beef patties for swiss steak in an unsealed bag, and ham in a baggie with no label or date. c. The chest freezer contained an open bag with ,d+[DATE] box of biscuits, 5 pizza crust in an undated open bag, a ,d+[DATE] box of opened cookies, an open, undated bag of 6 omelets, and an undated bag containing 5 slices of garlic bread. d. The kitchen area had a five-gallon bucket ,d+[DATE] full with powdered thickener with lid sitting on top of a bucket with an unsecured lid, a ,d+[DATE]-gallon bucket ,d+[DATE] full of salt and covered with plastic wrap containing two golf ball size holes. Interview on [DATE] at 9:40 AM, Staff H, Cook, stated she used the open gallons of white and chocolate milk for the breakfast meal that morning, as she didn't notice they had a best by date from the previous day. In addition, Staff H stated she used the best by date as the expired date, indicating the milk as expired, so she shouldn't have used the milk earlier for breakfast. (continued on next page)

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	05/15/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy titled Preventing Food Borne Illness Employee Hygiene and Sanitary Practices effective [DATE] instructed food service employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness and employees must wash their hands before coming in contact with any food surfaces, after handling soiled equipment or utensils, and during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. Facility policy titled Food Safety Requirements effective [DATE], instructed food that is stored in dry bins will be removed from original packaging, labeled, and dated. All foods stored in the refrigerator or freezer will be covered, labeled and dated. Interview on [DATE] at 9:45 AM, the Dietary Manager acknowledged the observed unlabeled, undated, and expired food items. Interview on 5/ ,d+[DATE] at 3:30 PM, the Administrator stated they expected the staff to not leave the scoop in the thickener, the staff should complete hand hygiene after touching the trash can lid and before preparing food/drink items, and all food items should be dated, labeled and secured.

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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. 49056 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (October 1 - December 31) review, facility staffing reports, employee time cards, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 15 residents. Findings include: The PBJ Staffing Data Report run date 5/1 /25 triggered for failing to have licensed nursing coverage 24 hours/day 4 or more days within the quarter with less than (<) 24 hours per (/) day licensed nursing coverage with specific infraction dates. The report reflected 65 dates with failure to provide 24 hour/day nursing coverage during October to December. Review of the Facility Daily Staffing Sheets and Nurse Schedules for the infraction dates revealed nursing shifts covered by the Director of Nursing (DON), Staff A, Registered Nurse (RN), Staff B, RN, and Staff C, RN. Review of time cards for the infraction dates revealed the facility had nursing services provided for 24 hours/day. On 5/7/25 at 2:00 PM the Administrator stated from October 1st to November 3rd, 2024 had a different management/corporation and they don't have access to that information at that time. The Administrator stated from November 4th, 2024 the Business Office Manager (BOM) and Administrator would submit the punches to the corporate PBJ software, then the corporation handled it from there. On 5/7/25 at 2:00 PM the Regional Nurse Consultant explained the facility had to send a weekly detailed report to their corporation on their staffing and if the facility utilized any agency staff. The Regional Nurse reported if the corporation found any discrepancies they reach out to the facility. On 5/7/25 at 2:21 PM per email from the [NAME] President Mission Management Services the PBJ process revealed the buildings have been re educated on the process for entering, reviewing, and submitting. Encouraged best practice is to complete payroll to ease the overall process. Once the data is entered the community reviews prior to submission for accuracy, in addition to Human Resources. The Regional staff reviews to ensure that PBJ is submitted timely and reviews for warnings that need to be addressed prior to submission. PBJ is submitted through their PBJ software.

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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. 40905 Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facility's past surveys, and staff interview, the facility failed to correct their own deficiencies for 4 of 14 areas of concern. The facility reported a census of 15 residents. Findings include: The current survey identified the following concerns previously cited with the prior survey team: a. QAPI program and plan. b. Comprehensive assessments and timing. c. Free from unnecessary psychotropic Medications/ PRN (as needed) Use. d. Food storage/prepare/serve sanitation. Review of the December 2024 cited deficiencies reflected the following concerns cited on the current survey: a. Failed to accurately code the hospice level of care and the usage of an antipsychotic medication on the MDS b. Failed to document non medical interventions attempted for a resident's behaviors prior to administering an as needed(PRN) antipsychotic medication c. Failed to prepare and distribute food in accordance with professional standards for food safety by the staff wearing gloves, touching other items with the gloves, and then with the same gloves touching food items served to the residents. Review of the February 2025 cited deficiencies reflected the following concerns cited on the current survey: a. Failed to document non medical interventions for a resident's behaviors prior to administering a PRN antipsychotic medication. Review of the May 2025 cited deficiencies reflected the following concerns cited on the current survey: a. Inaccurately coded residents' MDS assessments for the use of an anticoagulant (blood thinner) and the diagnosis of urinary tract infection. b. Failed to attempt a gradual dosage reduction for an antipsychotic medication. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Failed to serve food under sanitary conditions by a staff member not performing hand hygiene between touching a garbage can lid and then touching a resident's food/drink item. The facility's policy, QAPI Facility Plan revised November 2024, documented the QAPI plan is designed to establish and maintain an organized facility wide program that is data driven and utilizes a proactive approach to improving quality of care and services throughout the facility. On 5/8/25 at 2:07 PM, the Administrator acknowledged the facility did have repeat citations from previous surveys and felt the facility has worked hard and improved. Interview on 5/15/25 at 3:00 PM, when asked about the Directed Plan of Corrections for December 2024 and March 2025 being issued to the facility and the repeat citations, the Administrator stated the Regional Nurse has recently been involved with their QAPI program, assisting with the processes and audits, and reviewing the information collected. The ADM stated the Medical Director attended the monthly QAPI meetings via phone and in person every quarter, and has provided input to their areas of concern. The ADM stated they had daily morning meetings and during that time they review the audits, the 24 hour report for concerns, and any other new concerns. The ADM reported regarding the repeat deficiencies for sanitation in the kitchen, she just couldn't believe it happened, she didn't know what caused the failure, as the facility was doing very well other than the state observing the staff member for the first time during a survey and thought maybe it made them nervous. The ADM explained they provided education to all of the kitchen staff and audits have went well. In addition, the ADM explained about the psychotropic medication usage, the facility missed a medication issue when doing the audits, just in error. In addition, they changed the process involved with documenting behaviors before administering psychotropic medications from a past survey, but they didn't monitor the gradual dosage reduction requirements needed for psychotropic medications.