Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165376	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Pleasant Valley	17990 Spencer Road Pleasant Valley, IA 52767

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 26529 Based on observation, clinical record review, wound care provider and facility staff interviews, the facility failed to notify the physician of pressure ulcer deterioration and implement nutritional orders in an effort to promote healing for 1 of 3 residents (Resident #3) reviewed for pressure ulcers. The facility reported a census of 36 residents. Stage 3 Pressure Ulcer: Full-thickness skin loss: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. Slough tissue is defined as a layer of dead skin cells and debris that forms on the surface of a wound. It can be yellow, white, tan, or cream in color, and can be moist, stringy, or fibrinous. Slough can occur in both acute and chronic wounds. Eschar is defined as a dry, dark scab usually adherent to healthy underlying tissue, and might require chemical or mechanical debridement if the tissue does not fall away from the underlying tissue naturally. Findings include: Review of Resident #3 Minimum Data Set (MDS) assessment dated [DATE], revealed the resident scored 2 out of 15 on a Brief Interview for Mental Status, which indicated the resident had severely impaired cognition. The list of diagnoses included; hip fracture, arthritis, asthma and encephalopathy (a change in brain function caused by various conditions such as infection, metabolic disorders, toxins or trauma). The assessment identified Resident #3 had a Foley catheter, and always incontinent of bowel. The MDS revealed Resident #3 required substantial staff assistance to roll left and right, and had not attempted sit to stand, or chair/bed-to-chair transfers due to medical conditions. The MDS indicated Resident #3 required substantial staff assistance for toileting hygiene, shower/bathe self, and personal hygiene. Resident #3 Height and Weight documented as 65 inches (5 ft 5 inches) and 107 pounds. The MDS documented on admission Resident #3 had a surgical incision wound, and skin tears. The Risk of Pressure Ulcer/Injuries question Is this resident at risk of developing pressure ulcers/injuries? answered with a 0 (code for No). The Unhealed Pressure Ulcers/Injuries question Does this resident have one or more unhealed pressure ulcers/injuries? Answered with a 0. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of hospital records faxed to the facility on [DATE] revealed the Assessment/Plan included, in part: protein calorie malnutrition, with dietician consulted, have added high-protein supplementation 3 times daily. The Admission Assessment, dated 12/23/24 at 8:45 PM documented Resident #3 had the following wounds present at admission: a. Left inner forearm - skin tear b. Right anterior elbow - skin tear c. Left lateral thigh - surgical wound The Admission Assessment Care Planning section did not indicate a Focus, Goal or Interventions for any of the 42 care areas listed. Wound management was on of the care area options. A N Adv - Braden Scale for Predicting Pressure Ulcer Risk Evaluation completed on 12/23/24 at 9:40 PM indicated a score of 13.0. Per the Braden Evaluation Scoring, A score of 13 puts a resident at moderate risk for pressure ulcers. A score of 10-12 is considered a high risk. A Health Status Note dated 12/31/24 at 4:25 PM: Noted new skin issues upon skin rounds. MASD (moisture associated skin damage) to coccyx and skin tear to the upper L (left) back, new orders received for wound care and entered. Will continue to monitor. The N Adv - Skin Check note entered at 4:57 PM documented #012: New skin issue. Location: Right gluteus. Laterality/Orientation: Medial (towards the middle of body). Issue type: Skin tear .Length (cm - centimeters) 6.3 Width (cm) 6.4 Area (cm2) 0.1. Epithelial (area of new formed skin cells) 30%. Slough (area of wound covered by dead tissue, appearing yellow or white) 0%. Eschar (area of hard, dry, dark crust on the surface of wound often black or brown): 50%. Exudate (discharge) amount: Moderate. Exudate type: Sanguineous: Indicates active bleeding, typically bright red .Dressing saturation: None. A Dietary Progress Note, dated 1/3/25 at 5:43 PM for RD (Registered Dietician) Nutrition Assessment: DX (diagnosis) of PCM (protein calorie malnutrition) .Diet: regular, regular textures .Poor po (oral) intake <-50% of meal intake; averaging <25% .Braden 13; high risk for PI (pressure injury) .Nutrition DX: Agree with hospital DX of PCM. Meets criteria for moderate PCM of acute on chronic illness AEB (as evidenced by) inadequate oral intake <25% of meals >30 days with elevated nutritional needs .High risk for wt. (weight loss) and skin breakdown, poor wound healing .Recommendations: 1. Add nutritional shake 1 carton (120 ml) with lunch and dinner. 2. Offer House supplement 90 ml TID (three times daily) between meals. 3. Vit C 500 mg BID. 4. Weekly Weights for 4 weeks. 5. RD following as warranted and remains available as needed. A N Adv Skilled Evaluation note, dated 1/7/25 at 1:04 PM documented #008: Skin issue has been evaluated. Location: Right gluteus. Laterality/Orientation: Medial. Issue type: Skin tear .Length (cm) 13.5 Width (cm) 9 Area (cm2) 0.2. Epithelial: 10%. Slough: 30%. Eschar: 60%. Exudate amount: Moderate. Exudate: Serosanguineous: mixture of serum and blood .Dressing Saturation: Heavy >75%. Documentation of physician notification of the change in wound size, and heavy saturation of dressing not indicated in the Skilled Evaluation note. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Dietary Progress Note, dated 1/7/25 at 1:07 PM for RD Progress note r/t wounds: RD contacted by facility nurse to update on wounds. Buttocks/sacrum area of concern. Surgical site for repair of left femur fx (fracture). Improved from 9 skin tears to one. POC (Plan of Care): 1. Add liquid protein 30 ml QD (once daily). 2. RD following as warranted and remains available PRN (as needed). A N Adv - Skin Check note, dated 1/10/25 at 12:17 PM documented #001 Skin issue has been evaluated. Location: Right gluteus. Laterality/Orientation: Medial. Issue type: Pressure ulcer/injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 3 Pressure Ulcer/injury - full thickness skin loss. Wound acquired in house. Exact date: 12/31/24 .Staged by: In-house nursing. Length (cm) 16 Width (cm) 10.5: 1.2. Undermining (a condition where the edges of the wound separate from the underlying tissue, creating a cavity or pocket beneath the wound service): Yes. Undermining = 2 instances . Epithelial: 10%. Granulation (moist, pink or red tissue that forms in the wound bed during the healing process): 20% Slough: 20%. Eschar: 50%. Exudate amount: Heavy. Seropurulent: mixture of purulent (thick, opaque fluid that is typically yellow, green or white in color. It is a sign of infection .Dressing Saturation: Heavy >75% . A Health Status Note, dated 1/10/25 at 12:59 PM documented Received order for referral to [provider name redacted] wound clinic from MD and call placed to [provider name redacted] wound clinic for appt (appointment). Scheduler on another call at the time of call and message left for [name redacted] to call back to schedule this appt. DON (Director of Nursing) aware of the referral and call made to schedule. Called son to let him know of the referral to wound clinic due to deteriorating wound to coccyx. A N Adv Skilled Evaluation, dated 1/11/25 at 2:46 PM documented #011 Skin issue has not been evaluated. Location: Right Gluteus. Laterality/Orientation: Medial . A Health Status Note, dated 1/13/25 at 1:10 AM, documented Went into the resident's room earlier in the night and resident told this RN to get out of her room and don't touch me .Dressing to her buttocks area soaked with BM (bowel movement). Changed dressing as ordered . A Health Status Note, dated 1/13/25 at 8:55 AM documented Nurse went to resident room to preform wound care, and noted R (right) buttock wound has deteriorated over the weekend, and how has a significant depth, with continued breakdown. MD here in house rounding and called into room to assess the wound, and order to send out to hospital for further evaluation and treatment. A Health Status Note, dated 1/13/25 at 5:37 PM documented Call placed to follow up on resident and resident was admitted to the hospital for UTI (urinary tract infection), and ortho (orthopedic) consulted and resident will undergo surgery . Review of the Care Plan, Date Initiated: 1/14/25, Revised: 1/28/25 revealed a Focus area to address I have a Stage 3 pressure ulcer to my rt(right) buttock r/t (related to) immobility. Interventions, initiated on 1/14/25 included, in part: a. Administer Medications as ordered. Monitor/document for side effects and effectiveness. b. Administer treatments as ordered and monitor for effectiveness. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	c. Assess/record/monitor wound healing Measure length, width, and depth where possible. Assess and document status of wound perimeter wound bed and healing progress. Report improvements and declines to the MD (medical doctor). d. Follow facility policies/protocols for the prevention/treatment of skin breakdown. e. Monitor nutritional status. Serve diet as ordered, monitor intake and record. f. Monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs or symptoms of infection, wound size (length, width, depth), stage. g. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. h. The resident needs monitoring to turn/reposition at least every 2 hours, more often as needed or requested. i. The resident requires the bed as flat as possible to reduce shear. j. Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. The Care Plan, Date Initiated: 1/17/25 also had a Focus area to address I am incontinent of Bowel. Interventions, initiated on 1/17/25, included: a. Apply barrier cream as ordered. b. Ask encourage resident to use call system& report need to use BR (bathroom). c. Check resident AC (before meals), PC (after meals), HS (bedtime) & provide incontinence care as needed. d. Monitor for excoriation/skin breakdown. The Care Plan did not include a Focus area to address protein calorie malnutrition. Hospital discharge (on 1/17/25) instructions for visit date 1/13/25 diagnoses listed included: Wound infection - complicated; complicated UTI .sacral decubitus ulcer (pressure ulcer) .Instructions from your Doctor . for coccyx - Irrigate with saline. Gently tuck Dakin's (a solution used to treat and prevent infections in wounds) 0. 125% moistened gauze into wound depth and undermining and cover with ABD (abdominal pad), secure with tape. Perform daily and as needed. Additional orders included: reposition every 2 hours/repositioning wedges/bilateral heel boots, and Follow up with wound clinic upon discharge. A review of Physicians Orders revealed an order to start on 1/18/25 for Dakin's (1/4 strength or 0.125%) apply to coccyx topically one time a day for wound care. A review of the January 2025 Medication Administration Record (MAR) revealed a 9 documented on 1/18/25, and 1/19/25. No documentation of administration noted on 1/20/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Per the MAR Charts Codes, a 9 =Other/See Nurse Notes. A review of the Nurse Notes in the electronic record revealed a lack of documentation to explain the Chart Code used on 1/18/25 and 1/19/25. The review of Physician Orders revealed a lack of orders for: repositioning every 2 hours, use of repositioning wedges and bilateral heel boots. And the RD orders for Mighty Shakes, house supplement, and Pro-stat were not re-ordered. A N Adv-Skin Check note, dated 1/17/25 at 1:59 PM documented #001: Skin Issue has been evaluated. Location: Right Gluteus. Laterality/Orientation: Medial. Issue type: Pressure ulcer/injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure Ulcer staging: Stage 3 Pressure Ulcer/injury -full thickness. Wound acquired in-house. Exact date: 12/31/24. Staged by: In- house nursing. Length (cm): 6 Width (cm) 10.5 Depth (cm) 1. Epithelial: 10%. Slough: 30%. Eschar: 40%. Exudate amount: Heavy. Seropurulent. Dressing saturation: Heavy >75%. A review of the electronic health record revealed a lack of assessment information for the right gluteus Stage 3 pressure ulcer on 1/18/25, 1/19/25, and 1/20/25. A N Adv-Skin check note, dated 1/21/25 at 2:46 PM documented #002: Skin Issue has been evaluated. Location: Right Gluteus. Laterality/Orientation: Medial. Issue type: Pressure ulcer/injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure Ulcer staging: Stage 3 Pressure Ulcer/injury -full thickness. Wound acquired in-house. Exact date: 12/31/24. Staged by: In- house nursing. Length (cm): 10 Width (cm) 8.5 Depth (cm) 1.2 . Epithelial: 10%. Granulation:40%. Slough: 20%. Eschar: 0%. Exudate amount: Heavy. Seropurulent. Dressing saturation: Heavy >75%. A follow up Wound Clinic visit note, dated 1/23/25 noted Wound #2 Coccyx, pressure ulcer measured 10.9 cm x 8.2 cm x 1.9 cm. Wound status: not healed. The visit discharge information assessed Resident #3 Stable. The Wound Clinic discharge orders for the 1/23/25 visit included: a. Cleanse sacral pressure sore with NS, apply slightly moistened Hydrofera Blue (an antimicrobial dressing), cover with ABD gauze or Optifoam/sacral pad and tape, change daily and PRN. b. Increase protein in diet to at least 1 Gram per pound of ideal body weight a day. c. Add 20 Grams of collagen peptides BID. d. Add 20 Grams of whey protein BID. e. At least 2 protein shakes a day of facility choice. f. Return to the Wound Center in 1 week, scheduled 1/30/25 at 8:45 a.m. A review of the January 2025 MAR revealed the wound care orders implemented. The MAR lacked orders for an increase in protein, the addition of collagen peptides, whey protein and at least 2 protein shakes a day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. Foam wedges for positioning resident. c. Heel boots on while in bed. During an interview on 2/7/25 at 3:25 PM, the Director of Nursing (DON) and Corporate Nurse stated the RD recommendation should have been reviewed with the physician for continuation when Resident #3 discharged back to the facility on [DATE]. The DON stated staff should transcribe physician orders as written, unless contraindicated or changes required, and should clarify the order with the physician and transcribe the order as directed. During an interview on 2/10/25 at 9:03 AM, the Administrator stated a new process had been put into place on 2/7/25. After the nurse on duty transcribed new physician orders, they would be double checked by the following nurse (nurse on the next shift), and then triple checked by the DON to ensure all physician orders were implemented as directed. During an observation on 2/10/25 at 10:18 AM, Resident #3 in her room, in bed. An air mattress overlay on the bed, resident positioned on her left side, with her head positioned near the head of the bed, heel boots not on, resident did not have her call light. Resident #3 stated she was not comfortable due to her head position. Staff A, LPN asked to assess the resident's position. Staff A assisted the resident, and placed the heel boots on the resident. During an observation on 2/11/25 at 8:24 AM, Resident #3 positioned in bed on her left side, heel boots on, head of bed elevated approximately 10 degrees. Resident's hip appeared low. The facility Corporate Nurse stated the air mattress on the bed had a hole/was leaking. The Administrator stated she would contact the company and get a replacement air mattress, she should be able to have a new air mattress later that day. At 10:21 AM, the resident had been moved to another bed, pending replacement of the air mattress.