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	10/21/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, the facility failed to implement infection control practices when completing wound dressing changes for 1 of 1 resident (Resident #1) reviewed for wound care. The facility reported a census of 28 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] identified Resident #1 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: sepsis, renal insufficiency (kidney failure) and anxiety disorder. The MDS also identified Resident #1 required substantial/maximal staff assistance with toileting and repositioning and required partial/moderate staff assistance with showering, lower body dressing, putting on and removing footwear. The MDS also identified Resident #1 with two venous and arterial wounds present with applications of non-surgical dressings and medications to the wounds.On 9/16/25, the Care Plan identified Resident #1 with the problem of an actual skin impairment, venous ulcers, to his left lower leg and directed staff to monitor him weekly for and document/report to his physician as needed any changes in skin status; appearance, color, wound healing, signs/symptoms of infection, wound size (length X width X depth)On 10/2/25, the Care Plan identified Resident #1 with the problem of an actual skin impairment, venous ulcers, to his right lower leg. (previous one healed out 10/2/25) and directed staff to monitor me weekly for and document/report to my MD PRN changes in skin status; appearance, color, wound healing, s/s of infection, wound size (length X width X depth)On 10/20/25, the Care Plan identified Resident #1 with the problem of the need for contact isolation as he has ESBL (Extended-Spectrum Beta-Lactamase) in his urine from a urinary tract infection and directed staff to utilize Contact Precautions involve gown and glove use during high-contact resident care activities, follow facility's infection control policies/procedures when cleaning/disinfecting room, handling soiled linen, disinfecting equipment, etc. High contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Precautions are intended to be in place for the duration of a resident's course of antibiotic treatment.In an interview on 10/20/25 at 8:11 AM, Resident #1's family member reported an observation on 10/17/25 during the day shift when she observed Staff A, RN changing Resident #1's dressing at the nurse's station. She did not clean the wound and did not wash her hands in between. After she put the tape on the dressing, she put all the items she used in the medication cart along with the scissors without disinfecting the scissors. She did not wash her hands afterward.During an observation of wound care on 10/20/25 starting at 11:16 AM, Staff B, Registered Nurse (RN) donned isolation gown and gloves and removed the dressings from the right lower leg and removed her scissors from her pocket and cut through the soiled dressings and removed the collagen dressings and kerlix dressings. Staff B then removed her gloves, put the scissors in her pocket and while wearing the isolation gown left the room to get more supplies. At 11:27 AM, AM Staff B sprayed wound cleanser to wounds on Resident #1's right leg, and used the same gauze to cleanse each wound. The wounds and surrounding skin appear dark purple in color without edema noted and had a large amount of serous drainage noted on dressings. Staff B then left the room wearing the isolation gown, and without washing her hands. At 11:32 AM, Staff B returned to stand outside the room (while Resident #1 used the urinal) and donned a new isolation gown and gloves. Staff B dried the 3 wounds on Resident #1 right lower shin with the same gauze. Without a glove change or washing her hands, Staff B opened three new collagen dressing packets and applied them to the wound. At 11:42 AM, Staff B, RN removed the scissors from her pocket and without disinfecting them cut the dressing from Resident #1's left lower leg. The dressings were dated 10/19 and saturated with wound drainage. At 11:45 AM, Staff B, cleansed the wounds on the residents left lower leg with the same gauze. At 11:47 AM, Staff B, without a change of gloves or completing hand hygiene, opened 3 new collagen dressing packets and then picked dead skin from one of the wounds. Staff B removed her gloves, and without completing hand hygiene donned new gloves.At 11:52 AM, Staff B, without a change of gloves, cleansed the wound to the left second toe.At 11:57 AM Staff B picked up items that had been dropped on the floor, without a change of gloves she proceeded to place new dressing supplies in a drawer by the sink. Staff B also placed the scissors in the drawer, without first disinfecting them. During an interview on 10/20/25 at 1:01 PM, Staff A, RN reported the following: after removing soiled dressings or touching any other surfaces, after cleansing the wound, she would need to change her gloves, disinfect the scissors before and after cutting through the dressing. She would always disinfect them afterward. She also reported