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	11/18/2025

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 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** Based on clinical record review, policy review, and resident, staff and physician interviews, the facility failed to notify the physician of changes in a resident's condition, failed to intervene in a timely manner that included the collection of a urinalysis specimen for immediate processing, and failed to communicate laboratory results that indicated treatment was required to a resident's physician after their discharge for 1 of 3 residents reviewed with urinary catheters (Resident #4). The facility reported a census of 29 residents. Findings include: Review of the Minimum Data Set (MDS), dated [DATE], for Resident #4 revealed a list of diagnoses which included neurogenic bladder, paraplegia, stage IV (4) pressure ulcer of the left buttocks (a full-thickness tissue loss where skin, fat, and muscle have been destroyed, exposing underlying bone, tendon, or muscle), osteomyelitis (infection of the bone) of other site, anxiety and depression. The Brief Mental Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. The Assessment revealed the resident always able to make herself understood and always able to understand others. The assessment indicated Resident #4 required moderate staff assistance to transfer to and from bed and chair, bathing and toileting. The MDS documented the resident used a urinary catheter. Review of Physician Orders revealed, in part:a. Cleanse umbilicus catheter site with soap and water and pat dry daily on day shift, ordered 7/23/25.b. Attempt Clean Intermittent Catheterization to umbilicus with coude tip (type of catheter) pointing inferior, resident may perform by self, every 4 hours for maintenance document ml (milliliters) of urine output upon return, ordered 8/20/25.c. SP (suprapubic) catheter capped at all times except for cares and flushes, ordered 9/1/25.d. A physician order transcribed by Staff A, RN (Registered Nurse) on 10/17/25 at 11:32 a.m., with the facility Nurse Practitioner (NP) identified as the authorizing provider, directed staff: UA (urinalysis) with C&S (culture and sensitivity report) if indicated to be done Monday early AM to be sent to lab Monday AM.Review of Resident #4 Care Plan revealed the following Focus areas and associated interventions: a. I am at risk for urinary tract infection (UTI) related to use of urinary catheter, initiated 7/23/2025, with goal I will remain free from signs or symptoms of UTI, target date 11/3/25, included the following interventions: 1. Monitor resident for signs or symptoms of UTI and report abnormalities to MD, initiated 7/23/2025. 2. Provide resident with laboratory testing as ordered by MD, initiated 7/23/2025 Created on: 07/23/2025. b. I have a Urinary Tract Infection and am at risk of complications that does not meet McGeer criteria (a set of clinical definitions used to identify and monitor healthcare-associated infections (HAIs) in long-term care facilities), initiated 9/21/2025, with goal the resident's urinary tract infection will resolve without complications by the review date, and notation the goal resolved on 10/1/25, listed interventions that included: 1. Encourage adequate fluid intake, initiated 9/21/2025. Give antibiotic therapy as ordered. 2. Monitor/document for side effects and effectiveness, initiated 9/21/2025.3. Give antipyretics, analgesics and antispasmodics as ordered/as needed. Monitor/document for side effects and effectiveness, initiated 9/21/2025. 4. Monitor VITAL SIGNS as ordered and as needed. Notify MD of significant abnormalities, initiated 9/21/2025.5. Monitor/document/report to MD signs or symptoms of UTI: Frequency, Urgency, Malaise, foul smelling urine, dysuria, Fever, nausea and vomiting, flank (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain, Supra-pubic pain, Hematuria, Cloudy urine, Altered mental status, Loss of appetite, Behavioral changes, initiated 9/21/2025. 6. Obtain and monitor lab/ diagnostic work as ordered. Report results to MD and follow up as indicated, initiated 9/21/2025.7. Resident/family/caregiver teaching should include: Good hygiene practices: Females to wipe and cleanse from front to back, Clean peri area well after BM in order to help prevent bacteria in urinary tract, cranberry juice or prune juice to help keep urine acidic, Void at first urge. Do not hold urine for extended amount of time, Wear clean underwear daily, Take the full course of antibiotic therapy even if much improved after a few days of therapy, initiated 9/21/2025. Reveal of the electronic health record (EHR) revealed the following Nursing Progress Notes: a. On 10/12/25 at 11:17 p.m., Staff B, Registered Nurse (RN) stated Genitourinary: Cloudy in appearance. Mucous noted. No urinary complaints.b. On 10/16/25 at 5:08 a.m., Staff B, RN stated Genitourinary: Mucous noted. Cloudy in appearance. No urinary complaints.c. On 10/17/25 at 11:34 a.m., Staff A, RN stated New order for UA (urinalysis) to be collected early Monday AM to be sent Monday AM for C&S (culture and sensitivity) if indicated.d. On 10/18/25 at 11:26 p.m., Staff B, RN stated Genitourinary: Foul smell noted. Mucous noted. Hematuria noted. Cloudy in appearance. Urine retention noted. Urinary catheter intact.e. On 10/20/25 12:41 a.m., Staff B, RN stated Genitourinary: Cloudy in appearance. No urinary complaints. Urinary catheter intact. Obtained UA specimen at 12:04 a.m. and placed in cooler on ice for lab pickup.Review of the Resident #4 10/20/25 UA with C and S (culture and sensitivity - a lab test to help decide which antibiotic to prescribe) laboratory final results 10/25/25 revealed: Light yellow colored urine, clarity turbid (defined as thick with suspended matter, an abnormal result, normal result clear), 1+ blood (abnormal, normal negative for blood), Nitrites positive (abnormal, normal result negative), 3+ leukocytes (abnormal, normal result negative), greater than 50 white blood cells (abnormal, normal less than 6 white blood cells), moderate bacteria (abnormal, normally absent), mucous present (abnormal, normally absent), budding yeast present (abnormal, normally absent), white blood cell clumps present (abnormal, normally absent).The culture and sensitivity report revealed the resident's urine was infected with more than 100,000 CFU (colony forming units per milliliter) Klebsiella Pneumoniae and 20,000 to 25,000 CFU Enterococcus Faecalis, both bacteria not normally in the urine, the resident had a urinary tract infection (UTI) that required treatment with at least 2 different antibiotic medications.During an interview on 10/30/25 at 3:32 p.m., Resident #4 stated shad been telling staff for about 2 weeks prior to her discharge that she thought she had a UTI, they knew she was having symptoms of a UTI and didn't do anything about it until the day before she was discharged . Resident #4 stated on 10/17/25 Staff A, RN was in her room for her care and when she spoke to the nurse about her continued UTI symptoms. Staff A said we're not dealing with this today, we'll deal with this on Monday (10/20/25), and that's when they collected her urine specimen. Resident #4 stated on 10/24/25 she was feeling very ill, with fever of 101, rapid heart rate, flank pain, thick foul-smelling urine with mucous, called her urologist, they prescribed an antibiotic based on her symptoms 10/25/25, and she had not received the results of her UA that was done on 10/20/25During an interview on 10/30/25 at 11:03 a.m. Staff A, RN, stated she remembered writing the order for the UA on Resident #4, but didn't remember the specific's as to why it was ordered to collect the specimen on 10/20/25. The resident had reported to her that she was having cloudy urine, but she had not observed this herself, it was usually the CNA's (Certified Nursing Assistants) that emptied the graduate and cleaned the resident after she self-catharized, they would have observed her urine but they had not reported concerning symptoms to her in the time leading to her facility discharge. She might have written the order that way because if the lab doesn't have somebody that can pick up the specimen the facility didn't have a way to get the specimen to the lab because it's located 100 miles away. During an interview on 10/30/25 at 10:24 a.m. the Director of Nursing (DON) stated their lab came every Tuesday for lab draws and could gather specimens at that time, if staff needed labs done or a specimen collected on other days, they had to order it as a STAT (immediate) for lab to collect the specimen that day, and staff know to do that and have done that. During an interview on 10/30/25 at 4:11 p.m. Staff C, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility MDS nurse stated she had no understanding of why the UA ordered on 10/17/25 was scheduled for 10/20/25. If it was a STAT order or if their laboratory was unable to pick up the specimen staff could take specimens to 1 of the local hospital labs and Staff A must not have known that at the time, that was the only explanation she could offer. During an interview on 10/30/25 at 10:32 a.m., the facility's Advanced Practice Registered Nurse Practitioner (ARNP) stated she did see the notation about the resident's 10/20/25 UA results, did not remember the nurses speaking to her about this when she was at the facility on 10/19/25, and did not authorize the order for it. If the resident was having symptoms of an UTI, she would have directed them to collect the UA at that time and not wait 3 days. During an interview on 10/30/25 at 4:15 p.m., when quarried why she wouldn't have collected the urine specimen on 10/17/25 when she wrote the order at 11:32 a.m., Staff A, RN stated because she didn't think the laboratory would pick up the specimen. When asked if she obtained the order from Staff D, the facility ARNP, or had she contacted a different provider for the order, Staff A stated she notified Staff D about it. When informed that Staff D denied that any staff had informed her the resident had symptoms of a UTI or requested an order for a UA with C and S, and would have directed staff to collect the specimen at that time and not wait 3 days, Staff A stated she had nothing more to say about the matter.During an interview on 11/10/25 at 7:20 p.m., Staff B, RN, stated I didn't do anything wrong, I did everything appropriately and as I was instructed. When asked what that statement referred to, she stated it was about getting the UA on the resident, Staff A told her to get it early in the morning when she worked Sunday night, so it could go out Monday morning with labs. When asked about the order, to obtain the specimen 3 days after the order was written, was that normal? Staff B stated that is how it was ordered and that is what she did, she didn't do anything incorrectly. When asked if there were any problems with their lab, or getting the lab to pick up their specimens, Staff B stated the only issue she was aware of was there was a specimen on another resident that the lab wouldn't take because it was not labeled correctly, otherwise she was not aware of any problems with their lab transporting specimens when needed.During an interview on 11/10/25 at 10:40 a.m. Staff C, MDS nurse stated the 10/17/25 UA order was not authorized or signed by any medical provider because it was entered as a provider written order in their computer system, and those orders were not sent to the provider for written authorization. She learned to always enter orders in the computer as telephone orders and those went to the provider for authorization and signature. The facility was in the process of staff education related to the matter.The facility's Laboratory Services and Reporting policy, dated 2024, directed:a. The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law.b. The facility must provide or obtain laboratory services to meet the needs of its residents. c. The facility is responsible for the timeliness of the services.