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	09/09/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to ensure 1 of 7 residents reviewed for abuse remained free from physical abuse (Resident #16) when a staff member threw a box of gloves toward a resident. The facility reported a census of 36 residents. Findings: 1. The Minimum Data Set(MDS) assessment tool, dated 4/3/24, listed diagnoses for Resident #16 included depression, chronic pain, and chronic obstructive pulmonary disease. The MDS assessed the resident dependent on staff for toileting hygiene, showering, dressing, personal hygiene, and transferring. A Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicated intact cognition. The facility Freedom of Abuse Neglect and Exploitation Policy revised 8/2020, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. The policy stated the facility had zero tolerance for abuse of any type or manner and would address accordingly. The Care Plan, dated 3/27/24, included the Focus area: The resident is verbally aggressive related to Poor Impulse control. Interventions, dated 5/9/24, identified in the plan included: a. Analyze key times, places, circumstances, triggers, and what de-escalated behaviors. b. Assess and anticipate the resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain. c. Assess the resident's coping skills and support system. d. Assess the resident's understanding of the situation. e. Allow time for the resident to express himself and feelings towards the situation. f. Intervene before agitation escalated. g. Guide away from the source of distress. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Engage calmly in conversation and if the response was aggressive, walk calmly away, and approach later. A handwritten statement, dated 5/6/24, by Staff H Registered Nurse (RN) stated she heard screaming down the hall and Staff F Certified Nursing Assistant (CNA) stated she could not take these residents cursing them out and complaining while she cared for them. Staff H stated Resident #16 called the Staff F a b--h and Staff F took a box of gloves and threw it at the resident from the doorway and it hit the resident indirectly in the head (it hit the bed mattress before it hit patient). The resident stated he was not hurt, just mad. Staff F left the building. A handwritten statement, dated 5/6/24, Staff N, CNA stated when she and Staff F put Resident #16 to bed, the resident was impatient and made comments about waiting to go to bed. Staff N stated Staff F stated she was tired of everyone cursing at them and yelling. Staff N stated after they transferred the resident into bed, he began to yell and curse again and Staff F snapped and said she was tired of being mistreated while wiping their [expletive referring to buttocks] and that residents were ungrateful mother-----s and that Resident #16 was a sorry excuse. Staff N stated that she held Staff F back from the resident and Staff F threw soapy washcloths at the resident. Staff N stated the resident's roommate (Resident #26) started to get involved and was cursing. Staff N stated Resident #26 walked towards Staff F and Staff F stated if you punch me or put your hands on me it's going to go down. Resident #26 tried to hug Staff F and she started to calm down and walk away but Resident #16 started yelling again and Staff F returned and threw a box of gloves at the resident. The gloves hit the bed and then hit the resident in the head. An undated written statement by Staff G Licensed Practical Nurse (LPN) stated after the incident with Resident #16, she called Staff F and asked her what happened. Staff F stated that the resident called her names and she grabbed a box of gloves and threw it at the wall. Staff F stated the box hit the wall and then fell on the resident. During an interview on 9/3/24 at 2:01 p.m., Resident #16 stated a staff member threw a wheelchair but was not sure if it hit him or not. He stated the incident made him angry but he was not hurt. He stated he did not remember the staff member throwing the gloves or wash cloths and did not remember her threatening him. He stated the staff member was usually nice to him. During an interview on 9/3/24 at 2:20 p.m. Staff H Registered Nurse (RN) stated on the night in question, the facility was understaffed and staff were pretty stressed out and Resident #16 got the worst end of it. She stated she heard screaming from the other end of the building and she arrived near Resident #16's room and Staff F stated she was the one doing the screaming. Staff H stated the resident and Staff F were yelling at each other. The resident called her names and said she was a bad a-- b---- and Staff F said she would show him. Staff F grabbed a box of gloves which was not empty and whipped it at him with all of her strength. Staff H stated the gloves landed in the bed. She believed the gloves hit the resident but she could not say where. She stated when she threw the gloves, it had force behind it. She stated after this happened the resident was shook up. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/24 at 11:25 a.m. via phone, Staff G, LPN stated the Administrator called her and asked her to go to the facility due to Staff F yelling at Resident #16. She stated when she arrived, Staff F cared for Resident #136 and she asked Staff F to step out and she finished assisting Resident #136. Staff G stated she assessed Resident #16 that night and he had no red marks. She stated Staff F only wanted to work 4 days per week and they put her on the schedule 5 days per week and she came in all the time. She stated Staff F loved the residents but was too stressed out. Staff G stated Staff F had mental issues she needed to take care of. During an interview on 9/4/24 at 3:06 p.m., Staff F, CNA stated due to the incident with Resident #16 she was charged with intentional first offense Dependent Adult Abuse and had a court date. She stated on the day in question, they were short staffed. She stated on 5/6/24, those who worked in the building consisted of: herself, Staff H, RN and Staff N, CNA. She stated they were the only 3 in the building. Staff F stated after supper she needed to assist Resident #16 into bed and he had no sling under him for the mechanical lift. She stated Staff N was there but she was pregnant and was spotting so she could not have her lift. The resident stated he did not care and directed them to just get me into bed. She stated Staff N said she could help and they both picked him up and they all three fell into bed. The resident then told Staff F not to manhandle him and was then pissed and yelling. Staff F said he was verbally abusing her and he said something and she just snapped and said I don't give a f--*. Staff F stated f--* you and no one appreciates me. Staff F stated she knocked over the wheelchair and left the room. At this time Staff H arrived and the resident then said oh f--* that b---h and Staff F stated she took a box of gloves and threw it directly into the room at the wall. She stated the box did not hit the resident. She stated she did not throw any washcloths or threaten anyone. Staff F stated she was angry and went out the front door and cried. She said she would not return down that hall and then went to another hall and assisted another resident when Staff G came into the room and told her she had to go. She stated prior to the incident she had a lot of personal problems which she shared with the Administrator and had been in counseling. About a week prior to the incident on 4/29/24, she stated she had a mental breakdown. She came into the building for the second shift and every resident was soiled and she could not take it anymore. She stated other workers did not show up for work and she was completing sit to stand lifts by herself. She stated she understood her exploding was not ok but the facility put a lot on her. She went out to her car and started screaming and crying. The Administrator, Staff J, RN and her mother (who worked in laundry) came out to her car also and were looking at her. She told them to get away and she was embarrassed. Staff F punched her car window and cracked it and she threw a 40 ounce soda on her mother. She stated as she tried to reverse in her car, an ambulance and police car arrived. After speaking to the police, she went home. She stated this was around 5:00 p.m. She stated the Administrator texted her to see if she was ok but then asked her that night if she could come in at 10:00 p.m She did not end up coming back that night. During an interview on 9/5/24 at 9:10 a.m., Staff J, RN stated she was present when Staff F went to her vehicle and was upset. She stated they tried to get her calmed down but she was hitting her steering wheel and was distraught. She stated Staff F gave good care. During on observation on 9/5/24 at 10:39 a.m., Staff A and Staff K, CNAs transferred Resident #16 from his wheelchair to the bed using a mechanical lift. The Daily Staff Assignment sheet for 5/6/24 displayed the following staff for the evening shift: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Staff N CNA b. Staff F CNA until 8:30 p.m. c. Day charge nurse Staff H RN During an interview on 9/9/24 at 12:47 p.m., the Administrator was queried regarding ways she monitored and handled staff burnout. She stated she tried really hard to keep the facility staffed and tried to limit the amount of overtime. She stated she could tell by a staff member's energy, how they responded to residents, and their attitudes if they were getting burned out. She stated if they were clearly burned out, she would start filling the hours with other staff if she had them available. She stated with regard to Staff F, she got into an argument with her mother (the day the ambulance was called). She stated she was gone the next day or two but then was perfectly fine. She stated she did not ask Staff F to come in again that night. She stated after the incident with her mother, they watched her and she was fine. She stated with regard to the incident with Resident #16, she gave Staff H direction to have her leave the facility immediately and she knew that she should have been separated(from all residents). She said Staff F did what she was supposed to do without being told and was a really good aide. During an interview on 9/9/24 at 2:41 p.m., the Administrator stated residents should be free from abuse and this was their home.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to separate a staff member from residents immediately after an an allegation of abuse involving the staff member and Resident #16. The facility reported a census of 36 residents. Findings: 1. The Minimum Data Set(MDS) assessment tool, dated 4/3/24, listed diagnoses for Resident #16 which included depression, chronic pain, and chronic obstructive pulmonary disease. The MDS stated the resident was dependent on staff for toileting hygiene, showering, dressing, personal hygiene, and transferring and listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The facility Freedom of Abuse Neglect and Exploitation Policy revised 8/2020, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. The policy stated the facility had zero tolerance for abuse of any type or manner and would address accordingly. The policy stated if a staff member was accused of abuse by a resident or another staff person, that staff member was suspended pending investigation. A handwritten note, dated 5/6/24 by Staff N, Certified Nursing Assistant (CNA) stated when she and Staff F put Resident #16 to bed, the resident was impatient and made comments about waiting to go to bed. Staff N stated Staff F stated she was tired of everyone cursing at them and yelling. Staff N stated after they transferred the resident into bed, he began to yell and curse again and Staff F snapped and said she was tired of being mistreated while wiping their [expletive referring to buttocks] and that residents were ungrateful mother-----s and that Resident #16 was a sorry excuse. Staff N stated that she held Staff F back from the resident and Staff F threw soapy washcloths at the resident. Staff N stated the resident's roommate (Resident #26) started to get involved and was cursing. Staff N stated Resident #26 walked towards Staff F and Staff F stated if you punch me or put your hands on me it's going to go down. Resident #26 tried to hug Staff F and she started to calm down and walk away but Resident #16 started yelling again and Staff F returned and threw a box of gloves at the resident. The gloves hit the bed and then hit the resident in the head. An undated written statement by Staff G Licensed Practical Nurse (LPN) stated after the incident with Resident #16, she called Staff F and asked her what happened. Staff F stated that the resident called her names and she grabbed a box of gloves and threw it at the wall. Staff F stated the box hit the wall and then fell on the resident. During an interview on 9/3/24 at 2:01 p.m., Resident #16 stated a staff member threw a wheelchair but was not sure if it hit him or not. He stated the incident made him angry but he was not hurt. He stated he did not remember the staff member throwing the gloves or wash cloths and did not remember her threatening him. He stated the staff member was usually nice to him. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/24 at 2:20 p.m. Staff H Registered Nurse(RN) stated on the night in question, the facility was understaffed and staff were pretty stressed out and Resident #16 got the worst end of it. She stated she heard screaming from the other end of the building and she arrived near Resident #16's room and Staff F stated she was the one doing the screaming. Staff H stated the resident and Staff F were yelling at each other. The resident called her names and said she was a bad a-- b---- and Staff F said she would show him. Staff F grabbed a box of gloves which was not empty and whipped it at him with all of her strength. Staff H stated the gloves landed in the bed. She believed the gloves hit the resident but she could not say where. She stated when she threw the gloves, it had force behind it. She stated after this happened the resident was shook up. During an interview on 9/4/24 at 11:25 a.m. via phone, Staff G LPN stated the Administrator called her and asked her to go to the facility due to Staff F yelling at Resident #16. She stated when she arrived, Staff F cared for Resident #136 and she asked Staff F to step out and she finished assisting Resident #136. On 9/4/24 at 3:06 p.m., Staff F, CNA stated due to the incident with Resident #16 she was charged with intentional first offense Dependent Adult Abuse and had a court date. She stated on the day in question, they were short staffed. She stated on 5/6/24, those who worked in the building consisted of: herself, Staff H, RN and Staff N, CNA. She stated they were the only 3 in the building. Staff F, CNA stated after supper she needed to assist Resident #16 into bed and he had no sling under him for the mechanical lift. She stated Staff N was there but she was pregnant and was spotting so she could not have her lift. The resident stated he did not care and directed them to just get me into bed. She stated Staff N said she could help and they both picked him up and they all three fell into bed. The resident then told Staff F not to manhandle him and was then pissed and yelling. Staff F said he was verbally abusing her and he said something and she just snapped and said I don't give a f--*. Staff F stated f--* you and no one appreciates me. Staff F stated she knocked over the wheelchair and left the room. At this time Staff H arrived and the resident then said oh f--* that b---h and Staff F stated she took a box of gloves and threw it directly into the room at the wall. She stated the box did not hit the resident. She stated she did not throw any washcloths or threaten anyone. Staff F stated she was angry and went out the front door and cried. She said she would not return down that hall and then went to another hall and assisted another resident when Staff G came into the room and told her she had to go. On 9/9/24 at 12:47 p.m., the Administrator stated .with regard to the incident with Resident #16, she gave Staff H direction to have her leave the facility immediately and she knew that she should have been separated(from all residents). She said Staff F did what she was supposed to do without being told and was a really good aide. On 9/9/24 at 2:41 p.m., the Administrator stated residents should be free from abuse and this was their home.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on observation, staff interview, and policy review the facility failed to appropriately prime an insulin pen prior to administration for 1 of 1 insulin injections observed (Resident #13) and follow physician orders after a hospitalization for 1 of 2 residents reviewed (Resident #17). The facility reported a census of 36 residents. Findings include: During a medication pass on 9/04/24 at 6:58 a.m, Staff D, Licensed Practical Nurse (LPN) completed an accucheck on Resident #13 and determined the resident needed the base dose and an additional 12 units of sliding scale insulin. She preformed hand hygiene and opened the Lantus pen. She attached the safety needle to the end of the pen and then dialed the pen to 50 units. She then took the Glargine pen and put the safety needle on the end. She dialed the pen to 12 units. Staff D then entered the resident's room, explained the procedure to the resident, cleansed the area, and administered both insulin injections. During an interview on 9/04/24 at 10:19 a.m., Staff D explained she goes by what is on the sliding scale for the number to dial the pen to. She takes the pen out, puts it to that number, places the needle on, cleanses the area and notes the place it is administered. She then discards the needle and alcohol and replaces the pen in the bag in the medication cart. She acknowledged she was not aware that 2 units were supposed to be primed and wasted before dialing in the correct units. During an interview on 9/05/24 at 11:08 a.m., the Director of Nursing confirmed priming is one of the things staff need to do. Depending on the pen they might require staff to check for a bubble because theoretically you shouldn't have to prime if there is no bubble. She explained the facility was planning on a meeting with the nurses for education on this next week. The facility policy titled Diabetic Management, dated 9/2021, did not include instructions on the need to prime the insulin pen prior to dialing in the prescribed dosage. 25855 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #17 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 14 out of 15. The MDS listed diagnoses included: Type 2 diabetes mellitus with diabetic polyneuropathy. The MDS , coronary artery disease, and seizure disorder. The MDS revealed Resident #7 received insulin injections 7 out of 7 days in the look back period. A review of the Progress Notes revealed an Admission Summary, dated 9/5/24 at 5:24 p.m., Resident #17 readmitted to the facility after a hospitalization for UTI (urinary tract infection) with cystitis. Hospital After Visit Summary, dated 9/5/24, revealed Physician Orders for: a. Insulin Glargine 100 UNIT/ML (milliliter) injection. Inject 10 units into skin daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. POCT (Point of Care) Glucose 4 times daily before meals and at bedtime, notify Facility Physician if blood glucose less than 70 or greater than 140. c. Vitamin D PO. Take 5,000 units by mouth daily. A handwritten date of 9/9/24, with initials next to the Insulin Glargine, POCT glucose, and Vitamin D orders. A Progress Note, dated 9/9/24 at 3:13 a.m., documented: It was found that a couple of orders were not transcribed correctly upon resident's return from the hospital on 9/5/24. Added the orders today to: do accuchecks (blood sugar checks) AC & HS (before meals and at bedtime), Give 10 units Glargine insulin SQ every AM, and 5000 units of Vitamin D every AM. During an interview on 9/9/24 at 10:10 a.m., Resident #17 reported he did not have concerns with his care prior to going to the hospital. He stated he could not recall if he has missed any medications since returning from the hospital. During an interview on 9/9/24 at 11:39 a.m., the Director of Nursing (DON) stated the floor nurse would enter orders into the computer and the DON would double check them. She stated for the last few admits, she has entered the orders into the computer, however the nurses have not been double checking the orders. The DON stated the facilities current pharmacy does not enter the orders into the system. She stated she is working on having the pharmacy enter the orders initially and have the nurses double check the orders afterwards. When asked about Resident #17 insulin, glucose and Vitamin D orders the DON stated the facility had several new admits that week from another facility that had closed. The facility only has one floor nurse to double check the orders. The facility policy, dated October 2023, titled Physician Services section Physician's Orders Procedure, included, in part: 1. All Physicians' Orders for each resident shall be entered into the electronic medical record immediately upon receipt. Paper orders are also acceptable. 4. Transfer recommendations from the transferring facility for each resident are reviewed by the admitting nurse and attending physician and approved or revised by the resident's attending physician. The policy section, Processing of Medical Orders Procedure, included, in part: 1. Physician orders are to be noted by a licensed nurse .at the time that the orders are written/approved by the physician or received verbally or by telephone from the physician 2. The nurse who notes the order will transcribe the order onto the appropriate Medication Administration Record (MAR), Treatment Administration (TAR), and/or other records. 5. A licensed nurse between the hours of 12:00 midnight and 6:00 AM will review all physicians' verbal and/or telephone orders on a daily basis. The nurse will indicate his/her review and verification of accurate implementation by the nurse who noted the order, by documenting in red ink beneath the previous nurse's signature: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. 24-hour Physician Order Check b. The verifying nurse's name and professional designation c. The date (day, month, year) and time (including AM or PM that the Order was verified

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on observation, record review and staff interview the facility failed to provide baths for 2 out of 3 residents reviewed (Resident #6 and #32). The facility reported a census of 36 residents. Findings include: 1.The Minimum Data Set (MDS) dated [DATE] for Resident #32 indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating cognition intact. It further indicated diagnoses including: quadriplegia (inability to voluntarily move all limbs of the body from the neck down), depression and anxiety. The MDS assessed Resident #32 dependent on staff for transfers, bathing, dressing and personal hygiene. The Care Plan, initiate date of 7/15/24, revised on 9/4/24 included a Focus area to address I require assistance with ADL's (Activities of Daily Living) r/t (related to) Limited Mobility, Limited ROM (Range of Motion) and being paraplegic. Interventions included: BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated, and The resident is totally dependent on staff to provide bath/shower. Review of Resident #32 face sheet revealed an original admitted [DATE]. Review of the bath sheets revealed Resident #32 received a bath only on 8/15/24 and 8/22/24. During an interiew on 09/03/24 at 11:12 a.m., Resident #32 lying in bed flat on back not able to move any extremities. The resident stated I have only had two baths since I was admitted . It was probably a month after admitted that I even received my first bath. During an interview on 09/04/24 at 2:10 p.m., Staff B Certified Nurse Aide (CNA) stated residents should have a scheduled bath 2 times a week. If a resident refuses a bath we will document this. There is a piece paper at the front desk and then we document on it if they had their bath or refused. Staff B stated Resident # 32 was not one who would refuse his shower. If the showers get done it depends on the staffing if there is 2 aides then can only get 2-3 people in a shower, so sometimes baths and showers may get missed. It depends on who is working if they all get done. During an interivew on 09/05/24 at 1:13 p.m., the Director of Nursing (DON) stated if it is completed the bath or shower this need to be documented on the electronic health record. Residents should have a bath or shower 2 times a week and they have a list that is printed out every day and the CNA assigned to the resident is the one responsible for the bath/shower. This should be initialed on the sheet and if it is not it may be signed out on the electronic health record. I will spot check people and ask them if they got a shower. The facility provided a policy dated October 2023 titled Resident Hygiene Bath and Shower Standard which directed staff to bathe each resident daily, to include a sponge and/or bed bath five times weekly (or more often, if needed) including a tub bath, whirlpool bath or shower at least twice weekly. Tub and whirlpool baths or showers are scheduled for each resident and are given at various (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times of the day, modified according to the resident ' s condition, preferences, and desires, whenever possible. 49976 2. The MDS dated [DATE] for Resident #6 indicated a BIMS score of 15 out of 15 indicating no cognitive impairment. Listed diagnoses included: paraplegia (inability to voluntarily move part of the body) and multiple sclerosis. The MDS assessed Resident #6 dependent on staff for showering/bathing and transferring to the shower/bath. The Care Plan, revised on 5/31/2018, included a Focus area to address I have impaired capability of performing my ADL's as my functional ability has deteriorated r/t diagnosis of MS. Interventions includled I need staff to provide me with a bath/shower twice weekly and PRN (as needed). A review of the bath documentation revealed 5 baths were missed in the months of July 2024 (7/14/24, 7/21/24, and 7/25/24) and August 2024 (8/18/24, and 8/22/24) During an interview on 9/03/24 at 10:59 a.m., Resident #6 explained the facility doesn't have enough staff to give showers. He noted he was supposed to be a Thursday/Sunday bed bath and he had not been getting them. During an interview on 9/04/24 at 10:04 a.m., Staff B, CNA explained they have a color coded list of baths for the week- yellow for days and blue for nights. Staff must initial they are done by the end of the shift and give the completed sheets to the Director of Nursing. If they find any new skin tears staff tell the nurse and complete a skin sheet as well. At 2:12 PM Staff B noted Resident #6 is on night shift for bed baths. When it was during the day he was getting his bed baths consistently. She explained it all depended on the staffing. Sometimes baths get missed if they don't have enough staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, resident, family and staff interview, the facility failed to carry out interventions for 2 of 2 residents reviewed (Resident #17 and Resident #33). Resident #17 had a lab result return with a high white blood cell count and did not intervene for two days, and Resident #33 identified with 2+ pitting edema. The facility reported a census of 36 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #17 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 14 out of 15. The MDS listed diagnoses included: type 2 diabetes mellitus with diabetic polyneuropathy, coronary artery disease and seizure disorder. The MDS identified Resident #17 as requiring partial/moderate staff assistance with oral hygiene, toileting, and repositioning and was dependent on staff for assistance with showers, dressing, personal hygiene. A review of the lab report dated as collected 8/30/24 at 9:45 PM revealed order for a CBC (complete blood count), and BMP (basic metabolic panel) ordered STAT (immediately). The report listed the WBC (white blood cell count) as 26.67 thous/ml (thousand per milliliter. The reference range listed on the report for WBC 4.80 to 10.80 thous/ml. The results of the labs were posted on 8/31/24 at 1:15 a.m The results faxed to the facility on [DATE] at 2:29 a.m A review of the clinical record revealed an Infection Note, dated 9/2/24 at 6:41 a.m., Stat lab results received and noted WBC at 26.5, call placed to MD (medical doctor) due elevated WBC and change in condition, resident has been increasing lethargic, and vital fluctuating this AM vitals BP (blood pressure) 139/80 HR (heart rate) 91 manual. T (temperature in Fahrenheit) 97.3 R (respirations) 18 SPO2 (oxygen saturation in blood) 95% on RA (room air). MD with order to sent to ER (emergency room) for further evaluation and treatment with concern for sepsis. EMS (emergency medical services) called for transport to ER for further evaluation and treatment. Noted diaphoretic this AM, and some increased agitation. BS (blood sugar) 87. Report called to [hospital name redacted] to nurse [name redacted]. Will follow up on resident status. Family notified. A review of hospital ER records revealed: a. Vitals: T 97.8, HR 70, R 20, B/P 139/79, SPO2 95%. Denied pain b. Chief complaint: weakness and vomiting. Symptoms: weakness, confusion c. Weakness that began several days ago. WBC count from three days ago 26,000 d. Assessment: alert and oriented, no apparent distress. No Systems concerns noted e. Labs - WBC 13.29; Urine - turbid, moderate bacteria f. Admit for further evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. 11:55 a.m. reevaluation - pt (patient) stable h. UA (urinalysis) positive, CT (computed tomography) scans of abdomen negative. Treated for cystitis The hospital recorded revealed a principal diagnosis of acute cystitis without hematuria (blood in urine). Discharge orders included: levofloxacin 750 mg one tablet daily for 4 days. During an interview on 9/9/24 at 10:10 AM revealed Resident #17 sat up in his wheelchair, appeared well groomed, wearing clean clothing, properly positioned and appeared comfortable. When asked about his hospitalization , the resident stated he did not recall. During an interview on 9/5/24 at 9:01 AM, Staff D, LPN stated she CBC, and BMP to be done Friday [August 30, 2024]. The results should have been sent back to the facility the same day. Staff D stated she was off the weekend, and returned on 9/2/24 and printed out the lab results. Staff D stated the weekend nurse staff should have access to print the lab results. Staff D stated she reported the lab results to the physician on 9/2/24, and received orders for the resident to be sent to the ER for evaluation and treatment. During an interview on 9/5/24 at 10:10 AM, the Director of Nursing (DON) stated the nurse should have followed up looking for the lab results the following shift. The DON stated stated she was not aware of the labs being missed until Resident #17 had been sent out the ER, and cannot explain why the no one followed up on the labs draw. The DON stated she is responsible for scanning lab results and entering into the electronic medical record, but she did not remember seeing Resident #17's results A review of the facility policy, dated August 2023, titled Change in Condition/Incident Reporting Procedure indicated, in part: 1. When a resident displays a change in condition, Licensed Nurse will complete an identified (fall/incident/skin/weight/pain/infection/abuse) assessment or BAR (Situation, Background, Assessment, Recommendation) to determine symptom and clinical results. 2. Licensed Nurse to check physician orders to address. 3. If there is an actual change in condition, the resident's physician is notified promptly and validated as to information. Family/Responsible Party notified promptly. 4. Document the date/time of contacts and with whom you spoke. Document any new physician orders if indicated. Document resident condition and change in condition in nursing notes/BAR. Continue monitoring of resident's vital signs and pain level until determination made of potential delayed injury. 5. Immediately enter new orders on the resident's medical record and/or medication administration record if indicated. 6. Keep the Director of Nursing/Administrator abreast of the resident's condition change, potential for injury and response to new orders. 7. Report the status change and new physician orders to each shift on 24-hour report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Document resident response to new orders or physician directives. 9. Update the care plan and [NAME] if indicated to new interventions/orders. 10 Monitor change of condition for 72 hours in Alert Charting. 35434 2. The Minimum Data Set(MD'S) assessment tool, dated 5/8/24, listed diagnoses for Resident #33 which included multiple sclerosis, muscle weakness, and difficulty walking. The MD'S listed the resident's Brief Interview for Mental Status(BINS) score as 15 out of 15, indicating intact cognition. A 5/8/24 Care Plan entry directed staff to document edema (swelling) and notify the physician. Skilled Evaluations on 6/25/24, 6/28/24 and 6/30/24 stated the resident had 2+ pitting edema(the measurement of the severity of edema/deepness of pitting when pressure was applied, measured on a scale of 1-4 with 4 being the most severe, 2+ caused a slight pit that disappeared within 15 seconds)to the right and left lower legs and feet. The facility lacked documentation of physician notification of the edema or any follow-up interventions related to the edema. On 9/9/24 at 10:56 a.m. , the Director of Nursing(DON) stated if a resident had edema, staff should report it to the physician. On 9/9/24 at approximately 1:00 p.m. the DON stated she could not locate anything further about the resident's edema she had in June.

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F 0686 Level of Harm - Minimal harm or potential for 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** 25855 Based on observation, record review, resident and staff interview, the facility failed to complete dressing changes as ordered for a re-opening pressure ulcer for 1 of 1 residents (Resident #15) reviewed. The facility reported a census of 36 residents. Findings include: The Minimum Data Set (MDS) dated [DATE], identified Resident #15 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS listed diagnoses included: multiple sclerosis, depression, and polyneuropathy. The MDS assessed Resident #15 dependent on staff to complete oral hygiene, toileting, showers, dressing, putting on and taking off footwear, personal hygiene, repositioning and transfers. The Care Plan, dated 8/7/24, included a Focus area to address I have a stage 4 pressure area to my coccyx/left buttock. Interventions included: Administer treatments as ordered and monitor for effectiveness. A Progress Note, dated 8/7/24 at 8:16 a.m., communicated New order received from hospice and clarified to coccyx wound. Wash coccyx wound with wound wash, pat dry, apply calcium alginate and secure with adhesive optifoam. Floor nurse to manage daily dressings and Hospice nurse to assess and manage twice weekly. A review of Physician Orders revealed an order, dated 8/17/24, Wound care to coccyx wound: Cleanse with vashe (brand name of wound cleanser) wash, pack with plain packing soaked in vashe, cover with 3x3 optifoam. During an observation of wound care on 9/4/24 at 3:23 p.m., Staff D, LPN cleansed and dressed the wound as ordered. The wound bed appeared dark pink without signs of infection. A review of the August 2024 Treatment Administration Records (TAR) for the treatment order received on 8/7/24, indicated the order on 8/9/24, 8/10/24, 8/11/24, 8/12/24, 8/13/24, 8/14/24, 8/15/24, and on 8/16/24. The order discontinued on 8/16/24. The TAR indicated no treatment completed on 8/8/24. The August 2024 TAR also indicated the order received on 8/17/24 completed every day from 8/17/24 to 8/31/24. The September 2024 TAR indicated the treatment completed every day as ordered from 9/1/24 to 9/4/24. A review of the clinical record indicated the following pressure ulcer measurements: On 8/5/24 - 0.5cm x 0.5cm x 0.4cm (wounds measurements indicate length x width x depth, in centimeters (cm). Per facility Skin Condition report. On 8/14/24 - per hospice assessment, resident refused wound care. On 8/21/24 - 0.5 x 0.3 x 0 .2 per facility Skin Condition report (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24 - 2.5 x1.5 x 0.5 per hospice assessment On 8/28/24 - 2.5 x 1.5 x 0.5 per facility Skin Condition report On 9/4/24 - Hospice completed assessment - no measurements documented On 9/5/24 - 1.5 x 1 x 0.4 per facility Skin Condition report On 9/9/24 - 1 x 0.7 x 0.3 per facility Skin Condition report During an interview on 9/5/24 at 9:01 a.m., Staff D, Licensed Practical Nurse (LPN) stated Resident #15 dressing changes had not occurred as ordered. Staff D explained she does not work on Friday, Saturday or Sunday. She stated after completing a dressing change on a Thursday, she found the same dressing on the resident when she returned on a Monday. Staff D stated I don't always chart that when I find it, but I should. I have reported it to the Director of Nursing (DON). During an interview on 9/5/24 at 10:10 a.m., the DON stated she was first made aware of dressing changes not occurring as ordered a few weeks ago, and has since completed re-education. During an interview on 9/5/24 at 12:50 p.m., Resident #15 stated her dressing do not get changed on the weekends and her wounds were getting bigger. A review of the facility policy titled: Skin Management Standard dated as last revised January 2020, did not address the completion of dressing changes as ordered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on observation, record review and staff interview the facility failed to provide range of motion for 1 of 1 residents reviewed to maintain current level of range of motion to all extremities (Resident #32). The facility reported a census of 36 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #32 indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Listed diagnoses included: quadriplegia (inability to voluntarily move all limbs of the body from the neck down), depression and anxiety. The MDS indicated Resident #32 dependent on staff for transfers, bathing, dressing and personal hygiene. The Care Plan, initiated on 7/15/24, included a Focus area to address I require assistance with ADL's (Activities of Daily Living) related to limited mobility, limited range of motion and being paraplegic. Interventions included: The resident is non ambulatory and utilizes a broda chair and needs dependent assistance by staff to move around the facility. The Care Plan failed to direct staff to provide range of motion exercises to extremities. Review of a Occupation Therapy discharge summary, dated 7/27/24, revealed interventions included attempted active range of motion, weight shifting, staff education and resident education, wheelchair setup and repositioning to facilitate maximal participating in self care tasks. Progress and response to treatment Resident #32 attempted to participate in therapy tasks, however due to lack of active range of motion he is total dependence for all tasks. The discharge summary failed to provide a restorative program or functional maintenance program. Review of the Physical Therapy discharge summary dated 7/25/24 revealed the discharge recommendation to provide 24 hour care and shower chair with back. The discharge summary failed to provide a restorative program or functional maintenance program. During an interview on 09/03/24 at 11:13 a.m., Resident # 32 stated he is not getting any therapy and no range of motion he is quadriplegic and can not move his arms and legs by himself it is very frustrating. Resident #32 lying in bed on his back. During an interview on 09/05/24 at 11:06 a.m., the Director of Nursing, (DON) stated we do nothing for Restorative Nursing and we are working on getting it back in place. Staff should be providing some form of range of motion for residents who are not able to do for themselves. I don't how it is done here. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/05/24 at 11:11 a.m., Staff O, Physical Therapy Assistant (PTA) stated we did see Resident # 32 for Physical Therapy and Occupational Therapy. She revealed the therapy staff did not make recommendations for restorative nursing because they did not have anyone doing restorative nursing at the facility . All joints should have passive range of motion to all extremities and making sure the resident is turned and repositioned. We recommend the range of motion be done at least 2 times a day. We recommend range of motion to prevent contractures. The facility provided a policy title Restorative Nursing Standard dated August of 2021 which stated normal movement is an essential part of healthful living. Some individuals become incapable of moving their arms and legs without assistance. If ranges of motion exercises are performed with people who cannot move, joint movement capabilities can be maintained. This prevents the occurrence of painful, unsightly deformities. The range of motion program requires planning and consistency. The program and goals are to be established by a therapist or a licensed nurse. Whenever possible, the range of motion program should be performed on a daily basis, within the limitations or precautions specific to each resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35434 Based on clinical record review, policy review, and staff interview, the facility failed to follow the Care Plan and utilize a mechanical lift for 1 of 3 residents reviewed for mechanical lift transfers(Resident #16). The facility reported a census of 36 residents. Findings: 1. The Minimum Data Set(MDS) assessment tool, dated 4/3/24, listed diagnoses for Resident #16 included depression, chronic pain, and chronic obstructive pulmonary disease. The MDS assessed the resident dependent on staff for toileting hygiene, showering, dressing, personal hygiene, and transferring and listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Lifting and Transferring Residents, dated 10/31/23, directed staff to transfer a resident based on the resident's assessment. The Care Plan, dated 4/10/24, included a Focus area to address The resident requires assistance with ADL's (Activities of Daily Living) r/t (related to) Fatigue, Impaired balance, Limited Mobility. The Interventions listed included The resident is totally dependent on staff for transferring and is an assist of 2 with hoyer (brand name for a mechanical lift often used to describe all mechanical lifts.) During an interview on 9/5/24 at 3:06 p.m. Staff F Certified Nursing Assistant (CNA) stated on 5/6/24, she and Staff N needed to transfer the resident into bed but he didn't have a sling under him. The resident stated he didn't care and directed them to put him in bed. Staff F stated she and Staff N CNA said 123, lifted him, and they all 3 fell into the bed. During an interview on 9/5/24 at 7:33 a.m., Resident #16 stated two staff transferred him themselves with a gait belt and not using a mechanical lift. He stated this did not happen very often. During an interview on 9/5/24 at 9:48 a.m., Staff I CNA stated the resident was supposed to utilize the hoyer lift but the CNAs did not use it and she reported it to the nurses. During an interview on 9/5/24 at 10:53 a.m. Staff C Certified Medication Aide (CMA) stated she heard that staff did not use the mechanical lift with Resident #16. She stated the resident asked her why she couldn't transfer him into bed without the lift like others do. During an interview on 9/9/24 at 12:47 p.m., the Administrator stated Resident #16 utilized the hoyer lift to transfer and it was not acceptable to transfer him without it utilizing two staff members. She stated she was unaware this happened.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure the physician provided orders for a resident's immediate care and needs for 1 of 3 residents reviewed for a change in condition (Resident #33). The facility reported a census of 36 residents. Findings: 1. The Minimum Data Set (MDS) assessment tool, dated 5/8/24, listed diagnoses for Resident #33 included multiple sclerosis, muscle weakness, and difficulty walking. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Physician Services, revised 10/2023, stated the physician would develop, implement and monitor an effective and appropriate treatment plan to meet the resident's needs and achieve realistic goals. Physician's Progress Notes reflected the resident's current clinical and functional status, condition change(s) since the previous visit, and response to his/her plan of care, medication regimen, treatments, therapy, discharge plans, disposition and other factors relating to the resident. The Care Plan, dated 5/8/2024, included a Focus area to address I have hypertension (HTN, high blood pressure). An Intervention for the area included Monitor for and document any edema (swelling). Notify MD (physician). Skilled Evaluations on 6/25/24, 6/28/24 and 6/30/24 stated the resident had 2+ pitting edema (the measurement of the severity of edema/deepness of pitting when pressure was applied, measured on a scale of 1-4 with 4 being the most severe, 2+ caused a slight pit that disappeared within 15 seconds) to the right and left lower legs and feet. A review of the clinical record revealed a lack of documentation of physician notification of the edema or any follow-up interventions related to the edema. A Progress Notes, dated 7/4/24, written by Staff P Medical Doctor(MD) stated the resident had no new concerns today and did not address he resident's recent pitting edema. During an interview on 9/9/24 at 10:30 a.m., Resident #33 stated the only met the physician once time in July or August and stated he did not examine her. During an interview on 9/9/24 at 10:56 a.m., the Director of Nursing (DON) stated if a resident had edema, staff should report it to the physician. During an interview on 9/9/24 at approximately 1:00 p.m. the DON stated she could not locate anything further about the resident's edema she had in June.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49976 Based on clinical record review, facility assessment review, and staff interviews the facility failed to employ sufficient numbers of staff to meet resident needs. The facility reported a census of 36 residents. Findings include: 1. A review of the Facility Assessment, updated 8/01/24 revealed the facility needed 3 (three) Certified Nursing Assistants (CNA) for first and second shift if the census was 30 or more in order to meet resident needs. A review of the staff schedules from 8/01/24-9/02/24 revealed there were two CNA's for either partial or whole shifts 8 (eight) times on first shift and 13 times on second shift. During an interview 9/04/24 at 12:27 p.m., Staff C, Certified Medication Aide (CMA) acknowledged there are staff who come in late or oversleep, which leaves too few staff on the floor. During an interview on 9/04/24 at 12:36 p.m., Staff B, CNA noted she did not feel they had enough staff on the floor. She noted it depended on who she worked with if she could get everything done in a shift. She explained right now there were just 2 (two) CNA's as the third one took a resident to an appointment. She noted they don't often have call-ins or no shows, they just don't have enough staff scheduled. During an interview on 9/04/24 at 12:46 p.m., Staff A, CNA exclaimed right now no, they do not have enough staff. There have been only 2 (two) CNA's this day. Two is not enough. This past weekend it was only two of them [CNA's]. She was not sure if they just schedule two or if there were call-ins. Duties carry over to the next shift if there are only two working. She noted 3 (three) CNA's would be better. During an interview on 9/05/24 at 11:57 a.m., the Administrator explained she usually started the scheduling but the Assistant Director of Nursing (ADON) and Director of Nursing (DON) help with call-ins and scheduling also. They have several office staff that are CNA/CMA's that they can ask to help out if they are short on the floor during first shift. CMA's get pulled from medication duty to work the floor as well. In the afternoons they usually run 2 (two)CNA's but they are hiring more. They could usually ask someone to come in early or stay late. She explained staff called in 2-3 times per week and there was a lot of staff turnover. She noted staffing is based on census. Typically there were 2 (two) CNA's per shift on the weekends and they just hired more. There was also a policy where staff could be held over on their shift. She reported 3 (three) staff members quit recently because of this. They do borrow from other buildings at times if needed, and try to keep agency staff out. She expected all staff to answer a call light, no matter their title or job duties. 35434 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. The Minimum Data Set(MDS) assessment tool, dated 4/3/24, listed diagnoses for Resident #16 which included depression, chronic pain, and chronic obstructive pulmonary disease. The MDS stated the resident was dependent on staff for toileting hygiene, showering, dressing, personal hygiene, and transferring and listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The facility Freedom of Abuse Neglect and Exploitation Policy revised 8/2020, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. The policy stated the facility had zero tolerance for abuse of any type or manner and would address accordingly. A handwritten statement, dated 5/6/24, by Staff H Registered Nurse(RN) stated she heard screaming down the hall and Staff F Certified Nursing Assistant(CNA) stated she could not take these residents cursing them out and complaining while she cared for them. Staff H stated Resident #16 called the Staff F a b--h and Staff F took a box of gloves and threw it at the resident from the doorway and it hit the resident indirectly in the head(it hit the bed mattress before it hit patient). During an interview on 9/3/24 at 2:20 p.m. Staff H Registered Nurse(RN) stated on the night in question, the facility was understaffed and staff were pretty stressed out and Resident #16 got the worst end of it. She stated she heard screaming from the other end of the building and she arrived near Resident #16's room and Staff F stated she was the one doing the screaming. Staff H stated the resident and Staff F were yelling at each other. The resident called her names and said she was a bad a-- b---- and Staff F said she would show him. Staff F grabbed a box of gloves which was not empty and whipped it at him with all of her strength. Staff H stated the gloves landed in the bed. She believed the gloves hit the resident but she could not say where. She stated when she threw the gloves, it had force behind it. She stated after this happened the resident was shook up. During an interview on 9/4/24 at 3:06 p.m., Staff F CNA stated on the day in question [5/6/2024], they were short staffed. She stated on 5/6/24, those who worked in the building consisted of: herself, Staff H RN and Staff N CNA. She stated they were the only 3 in the building. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She stated after supper she needed to assist Resident #16 into bed and he had no sling under him for the mechanical lift. She stated Staff N was there but she was pregnant and was spotting so she could not have her lift. The resident stated he did not care and directed them to just get me into bed. She stated Staff N said she could help and they both picked him up and they all three fell into bed. The resident then told Staff F not to manhandle him and was then pissed and yelling. Staff F said he was verbally abusing her and he said something and she just snapped and said I don't give a f--*. Staff F stated f--k you and no one appreciates me. Staff F stated she knocked over the wheelchair and left the room. At this time Staff H arrived and the resident then said oh f--* that b---h and Staff F stated she took a box of gloves and threw it directly into the room at the wall. She stated the box did not hit the resident. She stated she did not throw any washcloths or threaten anyone. Staff F stated she was angry and went out the front door and cried. She said she would not return down that hall and then went to another hall and assisted another resident when Staff G came into the room and told her she had to go. About a week prior to the incident on 4/29/24, she stated she had a mental breakdown. She came into the building for the second shift and every resident was soiled and she could not take it anymore. She stated other workers did not show up for work and she was completing sit to stand lifts by herself. She stated she understood her exploding was not ok but the facility put a lot on her. She went out to her car and started screaming and crying. The Administrator, Staff J RN and her mother(who worked in laundry) came out to her car also and were looking at her She told them to get away and she was embarrassed. Staff F punched her car window and cracked it and she threw a 40 ounce soda on her mother. She stated as she tried to reverse in her car, an ambulance and police car arrived. After speaking to the police, she went home. She stated this was around 5:00 p.m. She stated the Administrator texted her to see if she was ok but then asked her that night if she could come in at 10:00 p.m She did not end up coming back that night. The Daily Staff Assignment sheet for 5/6/24 displayed the following staff for the evening shift: Staff N CNA Staff F CNA until 8:30 p.m. Day charge nurse Staff H RN During an interview on 9/9/24 at 12:47 p.m., the Administrator was queried regarding ways she monitored and handled staff burnout. She stated she tried really hard to keep the facility staffed and tried to limit the amount of overtime. She stated she could tell by a staff member's energy, how they responded to residents, and their attitudes if they were getting burned out. She stated if they were clearly burned out, she would start filling the hours with other staff if she had them available. 25855 During an interview 9/4/24 at 1:42 PM, Staff A, CNA stated with a census of 36 resident, the facility is usually staffed with one nurse, one med aide and 2 or 3 CNAs. She stated there have been one or two days she arrived to work and was the only CNA scheduled to work During an interview on 9/4/24 at 2:02 PM, Staff B, CNA stated with a census of 36 resident, the facility is usually staffed with one nurse, one med aide and 2 or 3 CNAs. She added there are 9 (nine) residents that require transfers with a mechanical lift which requires 2 (two)staff to assist (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/4/24 at 2:19 PM, Staff C, CMA stated she has been the only aide to come in to work at least once a month when people call in sick. During an interview on 9/5/24 at 9:01 AM, Staff D, LPN stated the facility usually is staffed with one nurse, one med aide and 2 (two) CNAs. She stated there have been 2 or 3 times she arrived to work and only one CNA was scheduled to work

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49976 Based on record review, staff interview, and policy review the facility failed to ensure the Dietary Manager met the minimum qualification of having a national certification for food service management and safety in the required timeframe. The facility reported a census of 36 residents. Findings include: The facility lacked record of the Dietary Manager's education or certification. They were unable to produce a schedule for the Dietician. The facility Employee Name Report, dated 9/3/24, indicated the Dietary Manger date of hire as 6/21/22. During an interview on 9/04/24 at 4:55 p.m., the Administrator stated the Dietary Manager had scheduled to take her certification test the previous week but the test was shut off in the middle of her taking it. The test rescheduled for this Tuesday [9/3/24] but she was called in to work due to a cook cancellation. She was rescheduling the test for next week [week of 9/9/2024]. During an interview on 9/05/24 at 9:25 a.m., the Administrator explained the dietician works remotely. She is never on site. She acknowledged the Dietary Manager not having her certificate was an issue. During an interview on 9/05/24 at 12:35 p.m., the Dietary Manger explained she had several years working as a Dietary Supervisor but did not take the necessary classes to qualify until this April. She noted she had to reschedule her certification test yet again. The facility lacked a policy indicating the necessary certification for Dietary Managers.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49976 Based on record review, observations, resident and staff interviews, and policy review the facility failed to serve at the safe temperature, and palatable. The facility reported a census of 36 residents. Findings include: A review of the Resident Council Minutes from May 2024 revealed documented complaints of food sometimes being cold. During an interview on 9/03/24 at 10:45 a.m., Resident #6 described the vegetables as overcooked and the hamburger tasted like sandpaper. He noted the food was not warm when it gets to his room on a room tray. During an observation on 9/03/24 at 1:05 p.m., a requested test tray food items temperature results: a. Mashed potatoes - 135.5 degrees Fahrenheit (F) b. Boiled carrots - 125.0 F c. Roast beef - 120.5 F When tasted, the carrots noted to be lukewarm and have a mushy consistency. The roast beef noted to be lukewarm. During an interview on 9/05/24 at 12:35 p.m., the Dietary Manager explained she expected food holding temperatures to be around 145 F. She expressed other steps may need to be put in place to keep the room trays warm. The facility undated manual, titled HACCP (Hazard Analysis and Critical Control Points) Procedures Manual, noted the minimum acceptable holding temperature for all hot foods to be 135 F. The manual directed staff to prevent soggy, overcooked vegetables.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 49976 Based on record review, observation, staff interview, and policy review the facility failed to assure food was properly prepared and appropriate to meet resident needs. The facility reported a census of 36 residents. Findings include: The facility menu titled Spring/Summer 2024 provided by the facility for 9/03/24 designated the following serving sizes to be given to residents with a pureed diet: a. Pot roast- #8 scoop size (4-5 ounces (oz.)) b. Gravy- 2 oz. c. Potatoes and onions- #10 scoop size (3-4 oz.) d. Carrots and celery- #16 scoop (2 1/4 oz.) e. Apple crisp- #10 scoop f. Wheat roll- #12 scoop (2 1/2-3 oz.) During an observation of the puree preparation on 9/03/24 at 1:28 p.m., the Dietary Manager (DM) failed to measure the beef and placed four chunks into the blender for four residents. Beef juice was added and the DM failed to measure the resulting puree before it was poured into a serving container. A 3 oz. scoop was used to serve the meat. Five #8 scoops of carrots with added juice was then measured, blended, and the volume not measured afterward before being placed in a serving container. An #8 scoop was used to serve the carrots. Seven (7) chocolate chip cookies and an unknown quantity of milk was blended, not measured, and poured directly into dessert bowls. Bread was not pureed or served and gravy was not made for the meal. During an interview on 9/05/24 at 12:35 p.m., the DM explained different managers trained her over the years and showed her two different ways to puree. One of the managers taught her to use a total volume chart to measure the amount at the end of pureeing and find the corresponding scoop size for the number of servings prepared. The other did not. She does not use it. An undated facility policy, titled Pureed Food Preparation, directed staff to portion out the number of pureed items needed to prepare pureed meals for all residents prior to blending. Only nutritive liquids are to be added for consistency. The policy failed to provide direction on measuring foods after blending to ensure adequate serving sizes.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49976 Based on clinical record review, staff and resident interviews, and policy review the facility failed to provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and Care Plan for 1 of 1 resident reviewed (Resident #6). The facility reported a census of 36 residents. Findings include: The facility posting titled Aspire of Pleasant Valley Mealtimes indicated meals times: Breakfast at 8 AM, Lunch at 12 PM, and Supper at 6 PM. The Care Plan revised 4/12/22 for Resident #6 documented the resident received dialysis M, W, F (Monday, Wednesday and Friday). During an interview on 9/03/24 at 10:45 a.m, Resident #6 stated he was missed altogether for supper last night (9/2/24). He reported he goes to dialysis Monday, Wednesday, and Friday and often doesn't get food afterwards. He gets back between 4-5 PM and eats in his room. He explained he needs assistance with eating so staff are supposed to help after they finish assisting in the dining room. They will leave the tray out at the nurses station but there isn't enough staff to assist him. They may give him a peanut butter and jelly sandwich after he pushes his call light. During an interview on 9/04/23 at 1:34 p.m., Staff A, Certified Nursing Assistant (CNA) reported staff forgot about Resident #6 for meals or she would have to go and ask for a peanut butter and jelly sandwich for him. She explained this has happened randomly. During an interview on 9/04/24 at 3:09 p.m., the Dietary Manager noted Resident #6 took a peanut butter and jelly sandwich with him to dialysis and was usually back in time for dinner. He always eats in his room. At one time he was feeding himself but now he needs assistance. She expected the CNA to get his tray from the kitchen to take it to him. She explained they had a cook that used to forget about him a lot. That cook is no longer working for the facility. An undated policy titled Food Preparation directed staff to use portion-control methods to assure the correct quantities are served to clients to meet the nutritional specifications as determined by the menu. Portions served are those listed on the menu for each food item.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49976 Based on observations, policy review, and staff interview the facility failed to prevent the potential for cross contamination due to lack of hand hygiene during preparation and plating of meals, proper storage of opened food items, uncovered garbage cans, and a lack of adequate chemical concentration in cleaning buckets. The facility reported a census of 36 residents. Findings include: During an observation of the kitchen on 9/03/24 at 10:12 a.m, the cleaning buckets were tested and lacked the appropriate chemical concentration for sanitizing surfaces. During the observation the following items were found in the freezer opened, unsealed, and undated: a. Cookie dough b. Chicken nuggets c. Ravioli d. Pizza crust e. Sausage patties f. Sausage links The dry goods pantry revealed almond extract with the lid broken off, unsealed and undated on the shelf. A continuous observation of meal preparation, and plating on 9/03/24 at 11:50 a.m., revealed: a. A garbage can found under the food prep counter with no lid, and a second can under the dish sink with no lid. b. Staff L, [NAME] wore gloves and grabbed two stacks of plates, touched a pan and a spatula, and failed to change gloves prior to plating cookies by hand. c. Staff M, [NAME] washed dirty dishes, failed to perform hand hygiene, and proceeded to whisk powdered drink mix and water together for meal service. d. Staff L wore gloves to handle plates, plate covers, and tongs, and failed to change gloves and plated 4 buns by hand. The tong handles for the meat fell into the pan and touched the food. The tongs used to plate meat, and the food then served to residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/04/24 at 10:40 a.m., the Dietary Manager re-tested the cleaning bucket solution, and the the test strip remained negative. During an interview on 9/05/24 at 12:35 p.m., the Dietary Manger explained she expected and educated staff not to wear gloves and touch items other than food. She further explained the facility was supposed to get the garbage lids as they knew that was an issue last survey and but they still haven't. An undated policy, titled HACCP Procedures Manual, directed staff to use proper hand washing for safe food preparation. Some food items, such as bread and rolls, should be handled with utensils or plastic gloves to decrease potential of infections. Staff must change gloves if handling different food items. The policy lacked direction regarding covering garbage cans, chemical sanitization, and food storage of opened items, labeling and dating of said items.

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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. 49976 Based on previous CMS-2567 review, staff interview and facility policy review the facility failed to ensure a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 36 residents. Findings include: Per review of the dia-hfd.iowa.gov website, the following deficiency had been previously identified per a Recertification Survey conducted from 2/19/23 to 2/16/2. The deficiency also cited during a Recertification Survey and Complaint Survey conducted from 9/3/2024 to 9/9/24: a. F725 - Sufficient Nursing Staff. Review of the Recertification Survey, and Complaint Survey conducted 11/13/23 to 11/21/23 revealed the following deficient practices, which also were identified during the Recertification Survey, and Complaint Survey conducted from 9/3/24 to 9/9/24: a. F677 - ADL Care Provided for Dependent Residents b. F684 - Quality of Care c. F804 - Nutritive Value/Appearance, Palatable/Preferred Temperature d. F812 - Food Procurement, Store/Prepare/Serve - Sanitary f. F880 - Infection Prevention & Control During an interview on 9/09/24 at 3:44 p.m., the Administrator explained the QAPI team meets at least quarterly and try to meet monthly to discuss issues. Data is collected via an online program and resident or employee complaints. The facility takes the top three issues to work on at a time and intend to follow it for one calendar year. The deficiencies from a survey are considered high priority. She acknowledged there was no plan in place for improvement of the previous survey deficiencies when she took the position as Administrator. She noted she was not surprised they had repeat deficiencies this survey. A review of the facility QAPI Management Plan, revised 1/2024 revealed, Once a Plan of Improvement has been implemented by the facility, the QAPI Committee should monitor the progress of the Plan. Should the issue continue to be a concern to staff, residents or facility customers, additional Resident Grievance/Concern/Complaint Reports should be submitted to the QAPI Committee for further review. Duties and responsibilities of the QAPI Committee included, but are not limited to: a. Reviewing and approving written policies that guide and limit the activities and decisions of the staff as they fulfill the objectives of the facility. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Establishing and enforcing policies to ensure that specific duties or functions are performed accurately and uniformly. c. Prioritizing areas of concern and identifying QAPI projects. d. Appointing Special Project Teams to investigate matters of concern and recommend Plans of Improvement to the QAPI Committee. e. Monitoring and evaluating the results of the Plans of Improvement and determining follow-up activities, if needed. f. Establishing benchmarks and data collection methodology for evaluating Plans of Improvement g. Review of clinical/operational results

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observations, clinical record review, and staff interviews the facility failed to follow accepted infection control technique and use Enhanced Barrier Precautions during wound care for 2 of 2 residents (Residents #15, and #87), and use Enhanced Barrier Precautions when emptying a urinary catheter collection bag for 1 of 1 residents (Resident #86). The facility reported a census of 36 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE], identified Resident #15 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS listed diagnoses included: multiple sclerosis, depression, and polyneuropathy. The MDS assessed Resident #15 dependent on staff to complete oral hygiene, toileting, showers, dressing, putting on and taking off footwear, personal hygiene, repositioning and transfers. The Care Plan, dated 6/6/24, identified a Focus area to address I have a need for Enhanced Barrier Precautions r/t (related to) wounds. Interventions included: a. Enhanced Barrier Precautions (EBP) involve gown and glove use during high contact resident care activities. b. Follow facility's infection control policies/procedures when cleaning/disinfecting room, handling soiled linen, disinfecting equipment, etc c. 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. d. Precautions are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. A review of Physicians Orders revealed an order, dated 8/1/24, to provide Wound Care R (right) lower abd (abdomen) superior (anatomical description used for location towards the head) wound; Cleanser and pat dry with gauze cover wound bed with calcium alginate and cover with adhesive optifoam daily one time a day for wound care. The orders included a Physicians Order, dated 8/124, RLQ (right lower quadrant) open wound: Cleanse with NS, pat dry, place calcium alginate and cover with border foam dressing daily one time a day for wound care. During an observation of wound care started on 9/4/24 at 3:00 p.m., an Enhanced Barrier Precaution sign noted to be on the door frame of Resident #15's room. Outside the door, in the hallway a storage bin contained Personal Protective Equipment (PPE - gowns and gloves). The bin contained an adequate supply of PPE. (continued on next page)

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	165376	A. Building B. Wing	09/09/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:05 p.m., after setting up a tray in the hall with a wound care items on a towel used for a barrier, Staff D, LPN entered the room. Staff D donned (put on) gloves, without donning a gown. At 3:06 p.m., Staff D removed dressings to right abdomen. The dressings contained a small amount of serosanguinous (thin, watery, pale red/pink drainage) drainage. Staff D then removed gloves, completed hand hygiene and donned new gloves. At 3:07 PM Staff D used the used Vashe soaked gauze to cleanse both abdominal wounds. Staff D cleaned the wounds from outside the wound bed to the inside. At 3:09 PM, Staff D after removing gloves and completing hand hygiene, left the room to obtain calcium alginate. Staff D completed hand hygiene, donned gloves and resumed wound care. Staff D did not don a gown. At 3:20 PM Staff E, Certified Nursing Assistant (CNA) entered the room to assist Staff D. Staff E completed hand hygiene and donned gloves. Staff E did not don a gown. 2. The Minimum Data Set (MDS) dated [DATE], identified Resident #87 as cognitively intact with a BIMS score of 15 out of 15. The MDS listed diagnoses included: paraplegia (paralysis of one half of the body), diabetes mellitus and neurogenic bladder (lack of bladder control). The MDS assessed Resident #87 as dependent on staff for assistance with toileting, showers, dressing, personal hygiene and transfers from bed to chair. The MDS identified Resident #87 occasionally incontinent of both bladder and bowel. The Care Plan, dated 9/2/24, included a Focus area to address I have potential impairment to skin integrity r/t diabetes, paraplegia, decreased mobility, and at times urinary Incontinency. Interventions Follow facility protocols for treatment of injury. The plan did not address the need for Enhanced Barrier Precautions. A review of the Physician Orders revealed an order, dated 9/4/24, Wound care to L (left) upper back, cleanse with NS pat dry and apply calcium alginate to the wound bed and cover with bordered foam dressing daily one time a day for wound care. A Skin Only Evaluation, dated 9/3/24, identified two shearing wounds on Resident #87's back. The assessment identified each wound as having minimal serosanguinous drainage. During an observation of wound care started on 9/4/24 at 2:36 p.m., an Enhanced Barrier Precaution sign noted to be on the door frame of Resident #15's room. Outside the door, in the hallway a storage bin contained an adequate supply of PPE. Staff D, LPN entered the room, completed hand hygiene and donned gloves. Staff D did not don a gown. Staff D soaked gauze in NS and proceeded to use to clean both wounds on the residents back. During an interview on 9/5/24 at 9:01 a.m., Staff D, LPN stated when a resident has more than one wound, a different piece of gauze should be used to clean each wound. Staff D stated if a resident is on EBP she should have donned an gown. She stated she did not wear a gown when doing wound care on Resident #15 or Resident #87. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/5/24 at 10:10 a.m., the Director of Nursing (DON) stated before completing wound care, she would expect nurses to don an isolation gown and gloves. The DON stated she expects nurses to use a different gauze for each wound cleansed, and to work from dirty to clean when cleansing a wound. A review of the facility policy, dated January 2019, titled Skin Management Standard Procedure for Dressing Change section directed staff, in part, to: 10. Cleanse wound from the center of the wound in a circular motion moving outward using cleansing agent ordered by the physician . 3. The Minimum Data Set (MDS) dated [DATE] identified Resident #86 as cognitively intact with a BIMS score of 15 out of 15. The MDS listed diagnoses included: coronary artery disease, heart failure and renal insufficiency. The MDS identified the resident required substantial/maximal staff assistance with lower body dressing and putting on footwear, toilet transfer, required partial/moderate staff assistance with showers, upper body dressing, repositioning and walking. The MDS documented Resident #86 had an indwelling catheter. The Care Plan, dated 8/26/24, included a Focus area to address I have the need for Enhanced Barrier Precautions r/t wounds with the use of a wound vac, JP (Jackson Pratt) drain to rt and lt flanks and indwelling catheter. Interventions included: a. EBP are recommended for residents known to be colonized or infection with a MDRO as well as those at increased risk of MDRO (Multidrug-resistant Organisms) acquisition. b. EBP involve gown and gloves use during high contact care activities for me. c. High contact care activities for me include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. During an observation on 9/4/24 at 7:17 AM, Staff B, CNA went to Resident #86 room to empty the catheter collection bag. An Enhanced Barrier Precaution sign noted to be on door frame to Resident #86 room. A storage bin noted to be placed outside the room with an adequate amount of PPE (gowns and gloves). Staff B entered the room, donned gloves and proceeded to empty the collection bag. Staff B did not don a gown. During an interview on 9/4/24 at 2:02 PM, Staff B, CNA reported when emptying a urinary drainage bag, she would need to put on gloves, get an alcohol wipe, plastic bag, a graduate and empty it into the graduate. The aides were told to wear a gown before taking care of anyone who has a catheter. She could not recall if she had donned an isolation gown before she emptied out Resident #86's bag. During an interview on 9/5/24 at 9:01 AM, Staff D, LPN reported staff should don an isolation gown and gloves before providing any care of Resident #86. During an interview on 9/5/24 at 10:10 AM, the DON reported when staff provide cares on Resident #86, she would expect them to don an isolation gown and gloves as the resident should be in Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy, dated July 12, 2022, titled: Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) listed examples of high contact care activities that require the use of a gown and gloves for Enhanced Barrier Precautions. These activities included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheotomy/ventilator), and wound care identified as any skin opening requiring a dressing.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49976 Based on clinical record review, staff interview, and policy review that facility failed to provide pneumococcal and influenza immunizations as required for 2 out of 5 residents reviewed (Resident #10, Resident #19). The facility reported a census of 36 residents. Findings include: The facility immunization record for Resident #10 indicated the last pneumococcal vaccine was administered on 8/27/22. There was no record of the vaccine being offered or declined since that time. The facility immunization record for Resident #19 indicated the last influenza vaccine was administered on 10/07/22. There was no record of the vaccine being offered or declined since that time. During an interview on 9/04/24 at 3:18 PM the MDS (Minimum Data Set) Coordinator explained she sends and collects permission forms for all the vaccines at the same time. She confirmed that she did not have a form for Resident #10. She acknowledged they do not know if the resident refused the vaccine or was not offered one. She also confirmed she could not find a declination or acceptance form for the influenza vaccine for Resident #19. The facility policy titled Infection Control Manual, updated 9/2023 instructed: 1. All residents of the facility, regardless of age and medical condition, must receive the influenza vaccine annually, conditioned upon the availability of the vaccines, unless there is a documented contraindication, decline or refusal of vaccine and depending on availability of vaccine. 2. Residents must be immunized against pneumococcal disease unless medically contraindicated or when the resident or the resident's legal representative refuses immunization. 3. Staff must complete the Pneumococcal & Influenza Vaccine-Information and Consent with the resident or family at the time of admission and each time offered. Place in the medical record.