| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165426 | A. Building<br>B. Wing | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aspire of Perry | 2625 Iowa Street<br>Perry, IA 50220 |

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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to manage his or her financial affairs.<br><br>41537<br><br>Based on record review, resident and staff interviews and policy review the facility failed to ensure 29 of 29 residents who use the facility to manage their personal finances had access to their funds as desired including evening and weekends. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) Assessment for Resident #24 dated 7/27/24 documented a Brief Interview for Mental Status (BIMS) of 15 indicated no cognitive impairment.<br><br>During an interview on 12/09/24 at 10:59 AM with Resident #24 revealed he did not have access to his personal fund on the weekend.<br><br>2. The MDS assessment for Resident #12 dated 7/20/24 documented a BIMS of 15 indicated no cognitive impairment.<br><br>During an interview on 12/10/24 at 11:51 AM with Resident #12 revealed he did not have access to his personal funds when he needs money, and informed it can take several days.<br><br>3. The MDS assessment for Resident #4 dated 8/1/24 documented a BIMS of 15 indicated no cognitive impairment.<br><br>During an interview on 12/10/24 at 11:35 AM with Resident #4 revealed she requested on 12/4/24 a gift card for $50 and has not received it yet. She then informed the lady in charge of Social Services ran out of cash and could not get it for her yesterday, and ever since she took over they have had problems with getting money and has been going on since June 2024.<br><br>During a follow up interview on 12/12/24 at 10:42 AM with Resident #4 revealed she requested on 12/4/24 a gift card for $50 and still has not received it.<br><br>During an interview on 12/12/24 at 11:12 AM with the facilities Social Services revealed she spoke with Resident #4 this morning and discussed the $50 gift card.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/12/24 at 10:30 AM with the facilities Senior Revenue Cycle Manager, revealed the facility had a $300 petty cash supply on hand and when it gets to $150 the facilities Social Services employee is to contact her and ask for more petty cash to keep the balance around $300. She revealed if multiple residents requested cash from their accounts on the same day or over the weekend the facility would have to divide the $300 out evenly and residents may not get the amount of money they request, even if it is in their account. She then informed if a resident requests cash over $99 they will give them a check and that takes around 48 hours to process. She then revealed if all 29 residents that had their personal funds managed by the facility requested $50 dollars on the same day equaling $1,450 the facility would not be able to give the residents their money as they only had $300 in the building at most at a time.<br><br>Record review of the facilities job description for Social Services Director, last revised 6/2021 lacked information this position would manage resident personal funds. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785<br><br>Based on interview, record and policy review the facility failed to provide residents and family with adequate notification of financial responsibility when Medicare Part A services were scheduled to be discontinued for 2 of 3 residents reviewed (Resident #6 and #34.) The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1) According to the Significant Change Minimum Data Set (MDS) dated [DATE], Resident #6 had a Brief Interview for Mental Status score of 15 (intact cognitive ability.) The resident was totally dependent on staff for toileting hygiene and dressing, and required substantial assistance with sit to stand transfers.<br><br>The Care Plan for Resident #6 showed that she was at risk for injury from falls related to impaired mobility. She required assistance of 2 staff with walking.<br><br>According to the Beneficiary Protection Notification Review (ABN), Resident #6 started Medicare Part A services on 4/16/24 and coverage terminated on 5/15/24. Question #1 on the form stated: Was an SNF (Skilled Nursing Facility) ABN Form CMS-10055 provided to the resident? the response was yes. The chart for Resident #6 lacked a signed 10055 form.<br><br>2) According to the MDS dated [DATE], Resident #34 had a BIMS score of 15 (intact cognitive ability.) The resident was independent with toileting, dressing, transfers and eating. She qualified for Part A Therapies, which included physical therapy.<br><br>The Care Plan updated on 10/3/24, showed that Resident #34 had recent radiation/chemotherapy treatments related to breast cancer.<br><br>According to the census tab in the electronic chart, Resident #34 was admitted to the facility on [DATE] with Medicare Part A services.<br><br>The ABN form for Resident #34, showed she had Medicare Part A Skilled Services beginning, 8/6/24 and scheduled for termination on 8/20/24. A note written on the form indicated that the Power of Attorney (POA) for the resident had been emailed and agreed to the Resident going off skilled services therapy on 8/20/24. The CMS-10055 form was incomplete with none of the options chosen, and the form lacked a signature.<br><br>On 12/12/24 at 2:30 PM, the Social Worker (SW) said that she notified the POA that Part A services were ending and she received an email with the response okay. She said that she understood that response to mean that the POA didn't want to continue or pay for services. When asked if she had presented the information on the 10055 form with the daily rate, and appeal options, the SW acknowledged that she should have gotten a signature and verification that the options were presented. The SW said that she couldn't answer for the missing form for Resident #6 because that was before she started working at the facility.<br><br>(continued on next page) |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | According to the facility policy titled: Beneficiary Notices, revised on 8/2024, the facility would prepare the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN), CMS 10055, and issue to the resident if the resident intended to continue services and the Interdisciplinary Team (IDT) had determined that serviced may not be covered under Medicare. The facility would inform the resident of potential non-coverage and document in the record that the resident understood they were accepting financial liability. Forms should be maintained in the binder in the Social Services. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>41537<br><br>Based on observation, staff interview the facility failed to keep the walls and floors in good repair in hallways and shower room. The facility also failed to keep the facility free of unpleasant ammonia odors (urine). The facility reported a census of 33 residents.<br><br>Findings include:<br><br>During an observation of the facility on 12/09/24 at 12:45 PM a strong unpleasant ammonia (urine) odor was present on the facilities west hallway.<br><br>During an observation of the facility on 12/10/24 at 11:51 AM a a strong unpleasant ammonia (urine) odor was present on the facilities south hallway.<br><br>During an interview on 12/12/24 at 12:44 PM with the facilities Director of Nursing (DON) revealed the facility should not have a smell of urine.<br><br>During onsite observations of the facility on 12/9/24, 12/10/24, 12/11/24, 12/10/24 and 12/16/24 the facilities East hallway had a broken recliner with brown substance in the hallway. Chipped paint on doors, walls, and floor boards as well as broken tile on the flooring were observed.<br><br>An observation of the facilities East hallway shower room on 12/16/24 at 2:42 PM revealed the shower room was missing tiles, 8 plus floor tiles stained with a brown substance, gaps in the shower wall that would allow water in, and lacked floor boards. |

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| F 0606<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Not hire anyone with a finding of abuse, neglect, exploitation, or theft.<br><br>41785<br><br>Based on observation, interviews and record review, the facility failed to ensure that background checks were cleared before staff worked in the resident population. An agency staff worked 3 shifts as a Certified Nurse Aide (CNA) with a suspended certification due to abuse. The same staff worked 1 shift passing medications as a Certified Medication Aide (CMA) without verification of education or certification as a CMA. The Director of Nursing (DON) started working for the facility before a background check had been completed. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1) In an observation on 12/9/24 at 3:31 PM, Staff B, CMA was at the medication cart and fumbled through the med cards to find medications. She went from the second drawer to the third drawer several times, then went to Staff A, CMA for assistance. He looked in the cart and pulled out a bubble pack of pills and handed it to her.<br><br>On 12/9/24 at 4:00, Staff B and Staff A were at the medication cart counting the narcotics at shift change. Staff A expressed frustration as he instructed Staff B to document on the narcotic sheet at the time of administration because the count for several narcotics had been off. Staff B said she was taught to document at the end of the shift.<br><br>On 12/10/24 at 8:57 AM Staff B said that she had just started at the facility and she did not get any orientation on the medication cart. She said that she was just given the keys and left to figure it out on her own. When asked where she received her medication aide certificate she said I didn't get it around here.<br><br>On 12/11/24 at 2:51 PM Staff A said he had trouble with Staff B the previous day on the medication cart because she didn't seem to understand. Staff H, Scheduler, said others had noticed that she was struggling, and many times, she had to ask someone to help her find the medications.<br><br>On 12/11/24 at 10:55 AM, Staff H, scheduler, said she did not have a file for Staff B or an orientation checklist. On 12/12/24 at 8:30 AM, Staff H said that some of the staffing agencies that the facility contracted with would provide access to their portal so she could see the staff information, but the Staffing Agency (SA) that hired Staff B had not provided copies of background checks or certification verification. Staff H said that she had reached out to them to get a copy of her file.<br><br>A Single Contact License and Background Check (SING) dated 12/11/24 at 12:07 PM, showed that Staff B was ineligible to work in Iowa and further research was required.<br><br>A report from the Direct Care Worker website on 12/11/24 at 2:28 PM, revealed that the status of Staff B, Certified Nurse Aide was listed as abuser.<br><br>(continued on next page) |

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| F 0606<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/12/24 at 9:14 AM, a representative from the SA said that she was in charge of the contracts and scheduling for the facilities, and not responsible for taking applications or doing the background checks. She said they had a Human Resources Department and did not understand how Staff B had been sent out to work in a facility when she was ineligible. The SA representative said that she talked to Staff B and asked her about her CMA certification. Staff B just responded that she would get a copy to her, but she would not tell her where she had gotten her education.<br><br>As of 12/17/24 at 12:45 PM, the SA had not returned requests to call on 12/12/24 at 11:25, and 12/16/24 at 1:28 PM.<br><br>On 12/12/24 at 11:52 AM, the Director of Nursing (DON) said that the day that Staff B was working on the medication cart was horrible. She said that the staff member was confused, and looked like she hadn't ever administered medications before. The DON said that the Agency was responsible for doing the background checks and the facility must be able to trust that they are doing their job to verify licensure and certification. She said that the facility did not have the time to be looking up the background of all agency staff.<br><br>An investigation of all the agency staff that were scheduled to work at the facility in the previous 3 months, revealed that Staff K, CNA did not have a valid certification as a nurse aid.<br><br>On 12/16/24 at 4:30 PM, the Administrator said that she was in touch with the agency and they did not have verification that Staff K, CNA had a certification. She said that Staff K hadn't actually worked at the facility because she called in sick the one day that she was scheduled.<br><br>According to the facility policy titled: Abuse Prevention Program, Prevention of Abuse, review date of 4/2025, the community would establish policies and procedures encompassing all facets of the Abuse Program, including screening. The abuse prevention/intervention program included conduction of background investigations per state regulations.<br><br>41537<br><br>2. Record review of the Director of Nursing (DON) Single Contact License & Background Check was ran on 11/22/24 and due to further research required not completed until 11/26/24.<br><br>Record review of the DON's time sheet revealed she was employed by the facility on 11/22/24 and worked the following hours:<br><br>11/22/24 - 8.75 hours<br><br>11/23/24 - 9 hours<br><br>11/24/24 - 7.5 hours<br><br>11/25/24 - 11.5 hours<br><br>11/26/24 - 11.5 hours<br><br>(continued on next page) |

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| F 0606<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/11/24 at 11:42 AM, Staff H, Certified Nurse Aide (CNA), Scheduler, revealed the Administrator instructed the DON she was allowed to start working at the facility but to stay away from residents.<br><br>During an interview on 12/12/24 at 12:44 PM, the DON revealed she started at the facility on 11/12/24 and was supposed to meet with Staff N, Human Resources Manager but she was not in the building to do her paperwork. She then informed she is aware a background check needs to be completed but didn't have it done. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>46873<br><br>Based on observation, clinical record review, staff and resident interviews and facility policy review, the facility failed to implement interventions to safeguard the dignity and wishes of Resident #34 after a Resident to Resident incident between Resident #34 and Resident #18. The facility reported a census of 33.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) Assessment of Resident #34, dated 8/12/24, identified a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented the resident experienced delusions during the 7 day look back period. The MDS documented diagnoses that included depression, bipolar disorder, psychotic disorder and schizophrenia.<br><br>The MDS Assessment of Resident #18, dated 10/6/24 identified a BIMS score of 15 which indicated cognition intact. The MDS documented the resident exhibited behavioral symptoms not directed toward others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, daily during the 7-day look back period. The MDS documented diagnoses that included anxiety and depression.<br><br>On 12/9/24 at 3:06 pm, Resident #34 reported she had recently been standing near the nurses desk, conversing with an employee. She stated Resident #18 was self propelling his wheelchair past her, and his arm went up her leg and then to her right buttocks. She said that he made a statement of not trying to do anything to her. She stated he touched her with his hand, and it was not a brush up with his arm. She said it made her wonder, as nobody expects anything like that to happen.<br><br>On 12/9/24 at 2:56 pm, Resident #18 stated he had bumped into Resident #34. He stated it was accidental and he apologized.<br><br>The Contact Form for Facility Reported Incidents revealed the date of the incident to be 12/5/24.<br><br>The Social Services Progress Note in the Electronic Health Record (EHR) of Resident #34, dated 12/5/24, authored by the Director of Nursing (DON), documented Resident #34 reported Resident #18 touched her bottom and it made her feel uncomfortable. The DON documented she made all necessary notifications. The note failed to document any interventions put in place to keep Resident #34 and Resident #18 separated.<br><br>The Social Services Progress Note in the EHR of Resident #18, effective date 12/6/24, created date 12/10/24 (late entry), authored by the Director of Nursing, documented Resident #18 thought he had bumped the foot of Resident #34 with his wheelchair as he was passing by. The note documented Resident #18 reported he patted her bottom to apologize and denied the touch as being sexual. The note failed to documented any interventions put in place to keep the two residents separated.<br><br>The Witness Statements by three facility staff members on duty on 12/5/24 revealed statements were gathered five days later, on 12/10/24. None of the statements documented any interventions put in place to keep the two residents separated.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/10/24 10:54 AM, The Care Plan of Resident #18 was reviewed. The Care Plan revealed a focus area dated 10/5/24 noted alleged inappropriate behavior towards a female. It failed to reveal any documentation of interventions to keep Resident #18 and #34 separated.<br><br>On 12/10/24 at 10:56 am, the Care Plan of Resident #34 was reviewed. It failed to reveal any documentation of interventions to keep Resident #34 separated from Resident #18.<br><br>On 12/10/24 at 11:43 am, the DON stated no staff had directly witnessed the incident between the two residents. She stated Resident #34 had felt Resident #18 touch her bottom and it made her feel uncomfortable. The DON stated Resident #34 had initially reported this to Staff I, Certified Nurse Aide (CNA) and Staff I then brought Resident #34 to the DON office. The DON further stated Resident #18 had admitted to patting the buttocks of Resident #34 as an apology for bumping into her. She stated she believed Resident #18's intentions were not sexual. She stated Resident #34 is not always the most reliable.<br><br>The DON further stated the two residents live on separate hallways. She stated the incident happened on a Thursday and she followed up with Resident #34 the next Monday. She said Resident #34 reported no further concerns. She added the two residents do not eat at the same table or attend the same activities. She stated the care plans had not been updated for either resident as the facility was still in the window for submitting a five day follow up on the incident. She stated she would update the care plans of both residents for staff to monitor the two residents to make sure they are kept apart. She said staff that were on duty on 12/5/24 did receive education but no further staff received any education at that time.<br><br>On 12/10/24 at 11:52 am, the State Surveyor was standing at the nursing desk waiting for Staff G, Licensed Practical Nurse (LPN) to complete a phone call. The State Surveyor observed the DON and Staff I, CNA speaking privately in the dining room.<br><br>On 12/10/24 at 11:55 am, Staff G, LPN stated when Resident #34 told her concerns to Staff I, CNA, Resident #34 was then taken to the DON office to notify her. She stated the facility has an abuse hotline flyer at the nursing station. She stated no direction was given to her to keep the residents separated but she stated she would consider that a given to do in this situation and kept an eye on the residents.<br><br>On 12/10/24 at 12:01 pm, Staff I, CNA stated she was sitting at the nurses station charting on 12/5/24 when Resident #34 came to her and told her Resident #18 had went past her in his wheelchair and had groped her behind. She stated she told Resident #34 she needed to report this to the DON and she took Resident #34 to the DON office. She stated the DON told her to keep the residents separated and to check on the residents every 15 minutes. She stated the 15 minute checks were to be completed every 15 minutes.<br><br>On 12/10/24 at 12:08 pm, Staff J, CNA stated she did know have any information on the interaction between Resident #18 and Resident #34. She stated she did not witness anything. She further stated she received no education regarding the two residents and nobody asked her to watch the two of them.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/10/24 at 12:09 pm, Staff A, Certified Medication Aide (CMA) stated he came on duty at 2:00 pm on 12/5/24. He stated he had no knowledge of any incident between the two residents and nobody at the facility had said anything to him about it. He was unaware of any incident prior to the State Surveyor asking him.<br><br>On 12/10/24 at 12:49 pm, Resident #34 was observed sitting at the far end of the dining room, near the exit to the patio. Staff J, CNA, stated that was not the resident's normal place to sit in the dining room.<br><br>On 12/10/24 at 12:55 pm, Resident #34 stated she was sitting in at a different table because a different resident was sitting in her normal spot when she arrived to the dining room. When asked about how she was feeling regarding Resident #18, Resident #34 replied she felt scared because she felt it could happen again because Resident #18 knew what he was doing.<br><br>In a follow up interview on 12/10/24 at 1:00 pm, Resident #18 stated the facility staff asked him what had happened during the incident and he told them. He stated he said he was sorry and the facility staff said ok. He denied receiving any direction or requests to keep distance from Resident #34.<br><br>The Care Plan of Resident #18 was updated on 12/10/24 by the DON to keep Resident #18 and Resident #34 separated as much as possible. It directed staff to not sit the two residents together in the dining room or at activities. It additionally directed staff to attempt to keep Resident #18 from going down Resident #34's hallway as much as possible.<br><br>The Care Plan of Resident #34 was updated on 12/10/24 by the DON. A revision was made to the Focus Area of risk for behavior problems indicating an incident of reporting to staff a male resident touching her on her bottom. It directed staff to keep Resident #34 and Resident #18 away from each other as much as possible, to not have them next to each other in dining room or activities. It additionally directed staff to discourage Resident #34 from being near Resident #18.<br><br>The Facility Policy Resident-to-Resident Altercations F600, revision date 10/2022 documented the following:<br><br>Point 2:<br><br>a. Separate the residents, and institute measures to calm the situation;<br><br>b. Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation;<br><br>c. Provide and document re-direction and provide protection as required by the situation<br><br>d. Notify each resident's representative and Attending Physician of the incident;<br><br>e. Review the events with the Nursing Supervisor and Director of Nursing, including interventions to try to prevent additional incidents;<br><br>f. Consult with the Attending Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem;<br><br>(continued on next page) |

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|---|---|---|---|
| | 165426 | A. Building<br>B. Wing | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aspire of Perry | 2625 Iowa Street<br>Perry, IA 50220 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | g. Make any necessary changes in the care plan approaches to any or all of the involved individuals<br><br>h. document in the resident's clinical record all interventions and their effectiveness; |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>46873<br><br>Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Comprehensive Minimum Data Set (MDS) Assessments within federal guidelines for 3 of 14 residents (#24, #31, #34) reviewed for MDS Assessments. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1. The Annual (Comprehensive) MDS of Resident #24 documented an Assessment Reference Date (ARD) of 10/30/24. On 12/16/24 the MDS was still displayed as In Progress. Twelve of the eighteen sections of the MDS were not completed. The MDS tab of the resident's Electronic Health Record (EHR) showed his last annual MDS was dated 10/30/23.<br><br>2. The Annual (Comprehensive) MDS of Resident #31 documented an ARD of 10/27/24. On 12/16/24, the MDS was still showing as In Progress. Twelve of the eighteen sections of the MDS were not completed. The MDS tab of the EHR showed the last comprehensive MDS, the resident's Admission MDS, was dated 10/27/23.<br><br>3. The Admission (Comprehensive) MDS of Resident #34 documented an ARD of 8/12/24. The MDS recorded the resident had an admitted to the facility of 8/6/24. Page 58 of the MDS recorded a completion date of 8/29/24, the 24th day of the resident's stay.<br><br>According to the 2024 Resident Assessment Instrument (RAI) Manual, for an annual (comprehensive) assessment, the Assessment Reference Date (ARD) must be within 366 days of the prior comprehensive assessment. The Assessment must be completed within 14 days of the ARD.<br><br>According to the 2024 RAI, for an Admission (comprehensive) assessment, the ARD must be no later than the 14th calendar day of the resident's admitted and must be completed by the 14th calendar day of the resident's admission.<br><br>On 12/12/24 at 4:30 pm, the Director of Nursing stated she is trying to take over the MDS duties as the facility does not have an MDS Coordinator. She stated she is currently locked out of the system but she will get the assessments caught up.<br><br>The Facility Policy MDS Assessment Coordinator F642, review date 11/2017 documented A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (RN). |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>46873<br><br>Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Comprehensive Minimum Data Set (MDS) Assessments following a significant change within federal guidelines for 3 of 14 residents (#6, #7 and #32) reviewed for MDS Assessments. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1. The Census Line portion of the Electronic Health Record (EHR) of Resident #6 documented the resident enrolled in hospice care on 10/3/24. The Significant Change MDS of Resident #6 documented an Assessment Reference Date (ARD) of 10/10/24. Page 58 of the MDS documented the MDS was signed as Assessment Completion on 10/28/24, three and half weeks following hospice admission.<br><br>2. The Progress Notes of Resident #7 documented hospice admission on 11/30/24. On 12/12/24 at 1:14 pm a staff member of the hospice company verified the admitted for hospice care to be 11/30/24.<br><br>The Significant Change MDS for Resident #7 documented an ARD of 12/10/24. On 12/16/24 the MDS was still displayed as In Progress. Thirteen of the eighteen sections of the MDS were not documented as complete.<br><br>3. The Census Line portion of the EHR of Resident #32 documented the resident enrolled in hospice care on 11/22/24. The Significant Change MDS of Resident #32 documented as ARD of 12/4/24. On 12/16/24, the MDS was still displayed as In Progress. Twelve of the eighteen sections of the MDS were not documented as complete.<br><br>According to the 2024 RAI, a Significant Change (comprehensive) assessment, the ARD must be no later than the 14th calendar day after determination that a significant change in the resident's status occurred. The RAI stated a Significant Change MDS is required to be performed when a terminally ill resident enrolls in a hospice program.<br><br>On 12/12/24 at 4:30 pm, the Director of Nursing stated she is trying to take over the MDS duties as the facility does not have an MDS Coordinator. She stated she is currently locked out of the system but she will get the assessments caught up.<br><br>The Facility Policy MDS Assessment Coordinator F642, review date 11/2017, documented A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (RN). |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assure that each resident's assessment is updated at least once every 3 months.<br><br>46873<br><br>Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Quarterly Minimum Data Set (MDS) Assessments within federal guidelines for 9 of 14 residents (#4, #5, #7, #8, #9, #12, #19, #23, #34) reviewed for MDS Assessments. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1. The Quarterly MDS for Resident #4 documented an ARD of 11/1/24. On 12/16/24 the MDS was still displayed as In Progress. Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the Electronic Health Record (EHR) of Resident #4 documented the prior quarterly MDS had an ARD date of 8/1/24.<br><br>2. The Quarterly MDS for Resident #5 documented an ARD of 11/10/24. On 12/16/24 the MDS was still displayed as In Progress. Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #5 documented the prior quarterly MDS had an ARD date of 8/10/24.<br><br>3. The Quarterly MDS for Resident #7 documented an ARD of 10/25/24. On 12/16/24 the MDS was still displayed as In Progress. Ten of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #7 documented the prior MDS, Admission MDS, had an ARD date of 7/25/24.<br><br>4. The Quarterly MDS for Resident #8 documented an ARD of 11/23/24. On 12/16/24 the MDS was still displayed as In Progress. Ten of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #8 documented the prior quarterly MDS had an ARD date of 8/23/24.<br><br>5. The Quarterly MDS for Resident #9 documented an ARD of 11/17/24. On 12/16/24 the MDS was still displayed as In Progress. Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #9 documented the prior quarterly MDS had an ARD date of 8/17/24.<br><br>6. The Quarterly MDS for Resident #12 documented an ARD of 10/20/24. On 12/16/24 the MDS was still displayed as In Progress. Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #12 documented the prior quarterly MDS had an ARD date of 7/20/24.<br><br>7. The Quarterly MDS for Resident #19 documented an ARD of 10/20/24. On 12/16/24 the MDS was still displayed as In Progress. Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #19 documented the prior quarterly MDS had an ARD date of 7/20/24.<br><br>8. The Quarterly MDS for Resident #23 documented an ARD of 11/7/24. On 12/16/24 the MDS was still displayed as In Progress. Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #23 documented the prior MDS, Annual MDS, had an ARD date of 8/7/24.<br><br>(continued on next page) |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 9. The Quarterly MDS for Resident #34 documented an ARD of 11/12/24. On 12/16/24 the MDS was still displayed as In Progress. Eleven of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #34 documented the prior MDS, Admission MDS, had an ARD date of 8/12/24.<br><br>According to the 2024 RAI, a Quarterly assessment must be completed no later than the 14th calendar day after the ARD date, and the ARD date must be no longer than 92 days following the prior assessment.<br><br>On 12/12/24 at 4:30 pm, the Director of Nursing stated she is trying to take over the MDS duties as the facility does not have an MDS Coordinator. She stated she is currently locked out of the system but she will get the assessments caught up.<br><br>The Facility Policy MDS Assessment Coordinator F642, review date 11/2017 documented A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (RN). |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>46873<br><br>Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Minimum Data Set (MDS) Assessments within federal guidelines for 2 of 14 residents (#26, #32) reviewed for MDS Assessments. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1. The Census Line portion of the Electronic Health Record (EHR) of Resident #26 documented the resident discharged from the facility on 10/22/24. The Discharge MDS of Resident #26 documented an Assessment Reference Date (ARD) of 10/22/24. On 12/16/24 the MDS was still displayed as In Progress. Nine of fifteen sections of the MDS were not documented as complete.<br><br>2. The MDS section of the EHR of Resident #32 documented a quarterly MDS with an ARD date of 10/20/24. On 12/16/24 the MDS was showing as export ready. The MDS revealed a completion date of 11/22/24. The facility had not yet transmitted the completed MDS to CMS (Centers for Medicare & Medicaid Services) per federal guidelines.<br><br>According to the 2024 RAI, a Quarterly assessment must be transmitted no later than 14 days after the completion date. The RAI also documents a discharge assessment must be dated for the date of the resident's discharge from the facility and must be completed no later than 14 days following the discharge date .<br><br>On 12/12/24 at 4:30 pm, the Director of Nursing stated she is trying to take over the MDS duties as the facility does not have an MDS Coordinator. She stated she is currently locked out of the system but she will get the assessments caught up.<br><br>The Facility Policy MDS Assessment Coordinator F642, review date 11/2017 documented A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (RN). |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>46873<br><br>Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual and facility policy review, the facility failed to fully develop and implement a Comprehensive Care Plan for 1 of 5 residents reviewed for Unnecessary Medications (Resident #6). The facility reported a census of 33.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) Assessment of Resident #6 dated 10/10/24 documented diagnoses that included diabetes and heart failure. The MDS documented the resident received insulin injections on 7 out of 7 days of the assessment reference period.<br><br>The Active Diagnoses of Resident #6 listed Diabetes Mellitus due to Underlying condition dated 4/15/2023.<br><br>The Active Orders of Resident #6 revealed an order for Insulin Glargine, dated 6/8/24, to be administered every night, and an order for Humalog Insulin, dated 6/13/24, to be administered three times a day based on the resident's blood glucose level.<br><br>The Comprehensive Care Plan of Resident #6, last reviewed 12/3/24, failed to reveal any documentation of the resident having the diagnosis of diabetes or orders for insulin.<br><br>The 2024 RAI, Page N-6, Planning for Care, High-Risk Drug Classes, documented the following:<br><br>High-Risk Drug Classes: Use and Indication (includes hypoglycemic drugs and insulin)<br><br>Target Symptoms and goals for use of these medications should be established for each resident. Progress towards meeting the goals should be evaluated routinely.<br><br>On 12/17/24 at 11:27 am, the [NAME] President of Operations stated her expectation is any active diagnosis which have specific medications and/or treatments for the resident should be included on the Care Plan.<br><br>The Facility Policy Comprehensive Care Plans, revision date 8/2022 documented the following:<br><br>Policy Statement: An individualized comprehensive person centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural and psychological needs is developed for each resident.<br><br>Guidelines, Point 2: The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS and physicians orders. Assessments of residents are ongoing and Care Plans are revised as information about the resident and the resident's condition change. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>41537<br><br>Based on record review, staff interview, and policy review the facility failed to review and revise 1 of 1 Care Plans for a resident who vapes (a device used for inhaling vapor containing nicotine and flavoring) at the facility (Resident #21). The facility reported a census of 33 residents.<br><br>Findings include:<br><br>During an interview on 12/09/24 at 9:29 AM with the Administrator revealed Resident #21 will occasionally vape.<br><br>Record review of Resident #21 Care Plan on 12/11/24 lacked instruction and direction regarding her vaping.<br><br>During an interview on 12/12/24 at 12:44 PM with the Director of Nursing (DON) revealed she would expect Resident #21 Care Plan inform she vapes with appropriate safety interventions.<br><br>Review of the facilities policy, Accident Prevention - Smoking Policy, effective 8/2024 instructed staff for residents whom wish to smoke will be evaluated for safe smoking per community protocol. The policy lacked instruction to implement into the residents Care Plan.<br><br>Review of the facilites policy, Comprehensive Care Plans, effective 8/2024 instructed the following:<br><br>Each resident's comprehensive Care Plan is designed to:<br><br>a. Incorporate identified problem areas;<br><br>b. Incorporate risk factors associated with identified problems;<br><br>c. Build on the resident's strengths;<br><br>d. Reflect the resident's expressed wishes regarding care and treatment goals if applicable;<br><br>e. Reflect treatment goals, timetables and objectives in measurable outcomes;<br><br>f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels;<br><br>g. Enhance the optimal functioning of the resident |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>46873<br><br>Based on clinical record review, staff interview and facility policy, the facility failed to implement and maintain a Restorative Program for 6 of 6 residents reviewed who require assistance to complete their Activities of Daily Living (Resident #1, #8, #9, #19, #30, #32)<br><br>Findings Include:<br><br>1. The Minimum Data Set (MDS) of Resident #1 dated 8/9/24 revealed the resident required supervision for sitting to standing, chair/bed-to-chair transfers and toilet transfers. The MDS revealed the resident required partial/moderate assistance for tub/shower transfer, total staff assistance for toileting hygiene and substantial assistance for bathing. The MDS revealed the resident received no Restorative Therapy services.<br><br>The Care Plan of Resident #1 failed to document any restorative nursing programs.<br><br>2. The MDS of Resident #8 dated 8/23/24 revealed the resident to be dependent upon staff for bathing. The MDS revealed the resident received no Restorative Therapy services.<br><br>The Care Plan of Resident #8 documented the resident to be incontinent of bowel and bladder. The Care Plan documented the resident required assistance with bathing, dressing, toileting, and transferring. The Care Plan failed to document any restorative nursing programs.<br><br>3. The MDS of Resident #9 dated 8/17/24 revealed the resident to require substantial assistance for eating and bathing. The MDS coded the resident to be dependent upon staff for oral hygiene, toileting hygiene, and dressing. The MDS coded the resident to require substantial assistance for sit to stand and toilet transfers The MDS revealed the resident received no Restorative Therapy services.<br><br>The Care Plan of Resident #9 failed to document any restorative nursing programs.<br><br>4. The MDS of Resident #19 dated 7/20/24 revealed the resident to be dependent upon staff assistance for oral hygiene, toileting hygiene, dressing and bathing. The MDS coded the resident to be dependent upon staff for transfers and required substantial staff assistance for bed mobility. The MDS revealed the resident received no Restorative Therapy services.<br><br>The Care Plan of Resident #19 failed to document any restorative nursing programs. A Care Plan goal for the resident listed as follows; I will maintain current level of function through the review date. (Target date 2/20/25).<br><br>5. The MDS of Resident #30 dated 9/19/24 revealed the resident to be dependent upon staff for bathing, hygiene, dressing, transferring and bed mobility. The MDS revealed the resident received no Restorative Therapy services.<br><br>The Care Plan of Resident #30 failed to document any restorative nursing programs. The Residents Care Plan identified contractures to the right upper and lower extremities.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. The MDS of Resident #32 dated 10/20/24 revealed the resident to require substantial staff assistance for dressing, toileting hygiene, and tub/shower transfers. The MDS revealed the resident received no Restorative Therapy services.<br><br>The Care Plan of Resident #30 failed to document any restorative nursing programs.<br><br>On 12/11/24 at 9:56 am, the Director of Nursing (DON) stated the facility does not have a Restorative Aide on staff. She additionally stated none of the nurses or Certified Nurse Aides performed any Restorative programs and none of the facility's residents currently had any Restorative program. She said the facility is short staff and she is working on hiring and hopes to include a Restorative Aide.<br><br>The Facility Policy Goals and Objectives, Restorative Services, Revision date 10/2024 documented a Policy Statement of Specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessments.<br><br>Point 1 - Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services.<br><br>Point 2 - Goals may include, but are not limited to:<br><br>a. Assisting the resident in adjusting to his/her abilities<br><br>b. Assisting the resident in developing and strengthening his/her physiological and psychological resources;<br><br>c. Encouraging the resident to maintain his/her independence and self-esteem;<br><br>d. Encouraging the resident to participate in the development and implementation of his/her plan of care; and<br><br>e. Other information as may become necessary or appropriate. |

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|---|---|---|---|
| | 165426 | A. Building<br>B. Wing | 12/17/2024 |

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| Aspire of Perry | 2625 Iowa Street<br>Perry, IA 50220 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>41537<br><br>Based on record review, staff interview, and policy review the facility failed to implement safety interventions for vaping (a mechanical device used for inhaling vapor containing nicotine and flavoring) for 1 of 1 residents who vapes at the facility (Residents #21). The facility also failed to ensure 1 of 1 residents who leaves for appointments had appropriate caregivers with her (Resident #8). The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1. During an interview on 12/09/24 at 9:29 AM with the Administrator revealed Resident #21 will occasionally vape.<br><br>Record review of Resident #21 Assessments in her Electronic Health Record (EHR) on 12/11/24 lacked nursing assessment of her vaping.<br><br>During an interview on 12/12/24 at 12:44 PM with the Director of Nursing (DON) revealed she would expect Resident #21 to have a smoking assessment completed and implement appropriate safety interventions as needed.<br><br>Review of the facilities policy, Accident Prevention - Smoking Policy, effective 8/2024 instructed staff of the following:<br><br>Residents whom wish to smoke will be evaluated for safe smoking per community protocol.<br><br>2. During an interview on 12/09/24 at 1:42 PM with Resident #8 Power of Attorney (POA) revealed on 12/3/24 resident #8 left the facility for a Cardiologist appointment on a bus unaccompanied by facility staff. She revealed she arrived to Resident #8 appointment shortly after she was dropped off by the bus and found her needing assistance to get checked in, as she is unable to do by herself.<br><br>During an interview on 12/12/24 at 12:44 PM with the DON revealed she would expect incompetent residents be assisted to appointments. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537<br><br>Based on record review, staff interview, and policy review the facility failed to ensure a Gradual Dose Reduction (GDR) was attempted yearly for 1 of 3 residents reviewed on an antipsychotic medication (Resident #15). The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment for Resident #15 dated 9/5/24 documented Brief Interview for Mental Status (BIMS) of 13 indicated severe cognitive impairment. The MDS documented he was admitted to the facility on [DATE] and received antipsychotic medications on a daily basis and a GDR has not been attempted. The MDS documented diagnoses of Non-Alzheimer dementia, depression, and bipolar disorder.<br><br>Record review of Resident #15 Orders in his Electronic Health Record (EHR) documented on 12/16/24 he had an active order of Seroquel (oral antipsychotic medication) 25 milligrams daily that started on 6/10/2023.<br><br>Record review of Resident #15 Care Plan on 12/12/24 documented an intervention to monitor for any psychotropic drug related problems such as dizziness, confusion and consult with pharmacy and his Doctor for dosage reductions when appropriate.<br><br>Record review of resident #15 Progress Notes documented on 2/29/24 a Telemed Psych Note Encounter and instructed a gradual dose reduction is not recommended for Resident #15 as this time to prevent decompensation (the failure to generate effective psychological coping mechanisms in response to stress, resulting in personality disturbance or disintegration).<br><br>During an interview on 12/10/24 at 11:42 AM with the Director of Nursing (DON) revealed she would expect all psychotropic medications used by residents be routinely monitored.<br><br>The facilities policy Tapering Medications and Gradual Drug Dose Reduction, last revised 9/2022 instructed the following:<br><br>For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if:<br><br>a. The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time could be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785<br><br>Based on observation, interviews and record review the facility failed to accurately document narcotic mediation use and failed to destroy narcotic medication after discontinuation for 2 of 3 residents reviewed (Resident #20, & #6.) The facility reported a census of 33 residents.<br><br>Findings include:<br><br>On [DATE] at 4:09 PM, Staff B, Certified Medication Aide (CMA) and Staff A, CMA were at the medication cart counting the narcotics and comparing the number of pills to the documentation on The Controlled Medication Utilization Record (CMUR.) They were frustrated, and Staff A told Staff B that she needed to document right away after giving narcotics and not wait until the end of the shift.<br><br>1) According to the Minimum Data Set (MDS) dated [DATE], Resident #6 had a Brief Interview for Mental Status score of 15 (intact cognitive ability.) The resident was totally dependent on staff for toileting hygiene and dressing and she required substantial assistance with sit to stand transfers.<br><br>The Care Plan for Resident #6 showed that she was at risk for injury from falls related to impaired mobility. She required assistance of 2 with walking and had chronic pain. Staff were directed to use medication as ordered and document side effects.<br><br>An order audit report, from the electronic chart, showed that Resident #6 had an order dated [DATE] at 5:11 AM, for Tramadol tablet 50 milligrams (mg) give 1 tablet every 8 hours as needed (PRN) for pain. The order was discontinued on [DATE] at 10:24 AM, and changed to Tramadol 50 mg Three Times a Day (TID) scheduled.<br><br>A review of the narcotics storage drawer on [DATE] revealed that the discontinued PRN package of Tramadol had not been destroyed and was still in the drawer.<br><br>The CMUR showed that on [DATE], one tab had been taken from the PRN order and on [DATE], 3 tabs had been used from the PRN order.<br><br>The CMUR for the Tramadol 50 mg TID order showed no tabs had been dispensed from this bubble package on [DATE], and just one was dispensed on [DATE]. The Medication Administration Record (MAR) for December was inconsistent with the CMUR and indicated that the resident received 3 doses of Tramadol 50 mg on [DATE].<br><br>2) The MDS dated [DATE], showed that Resident #20 did not have a BIMS assessment because she was rarely understood. She required substantial assistance with eating, sit to stand, toilet transfers and was totally dependent for hygiene and dressing.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Care Plan for Resident #20, updated on [DATE], showed that she was at risk for injury due to impaired safety awareness. The resident had chronic pain related to osteo arthritis and used antianxiety medication related to dementia. She was at risk for alterations in nutritional status and had diagnoses that included chronic kidney disease and heart failure.<br><br>A review of the narcotic drawer on [DATE] at 4:10 PM, reveled that Resident #20 had 5 bubble pack cards of Ativan tablets with expired orders.<br><br>1. 60 tabs of 1 mg Ativan delivered on [DATE] for the order; ,d+[DATE] tab in the morning and 1 mg in the afternoon, 1 mg at bedtime.<br><br>2. 30, ,d+[DATE] tabs of Ativan 1 mg. delivered on [DATE] for the order: ,d+[DATE] tab in the morning 1 mg in the afternoon and 1 mg at bedtime. A sticker in the upper left corner read: morning<br><br>3. 8, 0.5 mg Ativan tabs delivered on [DATE] for order: 1 tab at 2 PM, 2 tabs at night. A sticker on left corner read: bedtime<br><br>4. 8, 0.5 mg tabs Ativan delivered on [DATE] for order: 1 tab at 2 PM, 2 tabs at night. Sticker on left corner read: afternoon<br><br>5. 10, 1 mg tabs Ativan delivered on [DATE] for order: 1 tab three times daily and 1 every 4 hours as needed.<br><br>The following medication audits were found in the electronic chart orders tab:<br><br>1. Order dated [DATE] at 10:10 PM, Ativan 1 mg every 4 hours as needed for agitation/restlessness. Discontinued on [DATE] at 10:18 AM.<br><br>2. Order dated [DATE] at 10:07 PM, Ativan 1 mg three times a day for agitation and restlessness. Discontinued on [DATE] at 4:26 PM.<br><br>3. Order dated [DATE] at 2:00 PM, Ativan 1 mg one tab in the afternoon. Discontinued on [DATE] at 10:09 PM.<br><br>4. Order dated [DATE] at 1:50 AM, Ativan 1 mg in the evening. Discontinued on [DATE] at 1:50 PM.<br><br>5. Order dated [DATE] at 4:33 AM, Ativan 0.5 mg. in the morning for anxiety. Discontinued on [DATE] at 10:16 AM.<br><br>6. Order dated [DATE] at 4:29 AM, Ativan 1 mg two times a day for anxiety. Discontinued on [DATE] at 10:17 AM.<br><br>The CMUR for Ativan 1 mg. three times daily and 1 ever 4 hours as needed, showed that Staff B signed the CMUR on [DATE] and indicated that one tab had been given that day.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 5:57 AM, Staff E, Registered Nurse (RN) said that when a narcotic medication was discontinued, they destroy the tabs with two nurses and have a new card with the new orders. She looked at the bubble packages in the drawer for Resident #20 and acknowledged that those should not have been in the drawer anymore because the resident was on Hospice and no long swallowing pills, they were using the liquids.<br><br>On [DATE] at 2:30 PM, The Director of Nursing (DON) said that she would expect the nurses to destroy any narcotics that had been discontinued and to make sure that this was completed with a second nurse, and signed.<br><br>According to a facility policy titled: Medication Storage, last revised on [DATE], Schedule II drugs would be counted at the beginning and end of every shift, with count compared to Scheduled II medications ordered. |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785<br><br>Based on observation, interview and record review the facility failed to provide the therapeutic meals as ordered for 3 of 7 residents with altered diets (Resident #30, #22 and #3.) Resident #30 had orders for a pureed diet and was served breakfast with visible chunks, Resident's #22 and #3 had orders for a mechanical soft diet and were served crunchy garlic toast. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1) According to the Minimum Data Set (MDS) dated [DATE], Resident #30 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits.) The resident was totally dependent on staff assistance for toileting hygiene, dressing, personal hygiene, chair to bed transfers. The resident was on a mechanically altered diet and a feeding tube for nutrition.<br><br>The Care Plan last updated on 9/23/24, showed that Resident #30 had impaired communication and said very few words. He required assistance with Activities of Daily Living (ADLs) related to an amputation above the left knee and he was bedfast most of the time. He required assistance with eating with pureed foods, as well as tube feedings during the day.<br><br>The orders tab in the electronic chart showed an order dated 10/11/23 at 12:04 PM, for a regular diet, pureed texture.<br><br>In an observation on 12/10/24 at 8:20 AM, Resident #30 was in a wheel chair at the dining room table. An unidentified staff person assisted him with eating the pureed eggs and toast with green peppers. The eggs contained visible chunks of green peppers that were not creamed as per a pureed textured diet.<br><br>2) The MDS dated [DATE], showed that Resident #22 had a BIMS score of 3 (severe cognitive deficit.) The resident required substantial assistance with hygiene, dressing, sit to stand and toilet transfers. She was on a mechanically altered diet and required set up assist with eating.<br><br>The Care Plan updated on 9/26/24, showed that Resident #22 had impaired cognitive function/dementia related to metabolic encephalopathy. The resident had oral/dental health problems, edentulous poor oral hygiene. Staff were to serve the diet as ordered, consult with dietitian if changes in chewing or swallowing problems were noted. Resident #22 had nutritional problems related to dysphagia and speech therapy recommended a mechanical soft diet with thin liquids.<br><br>3) The MDS dated [DATE], showed that Resident #3 had a BIMS score of 9 (moderate cognitive deficits.) He required substantial assistance with oral hygiene, toileting hygiene, and dressing, and set up assistance only with eating a mechanically altered diet.<br><br>The Care Plan updated on 10/3/24, showed that Resident #3 had alterations in cognition related to dementia, staff were to monitor intake to assure an adequate fluid intake to prevent dehydration and to provide and serve diet as ordered.<br><br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An order dated 4/8/24 at 10:05 AM, Showed that Resident #3 had a regular diet order with mechanical soft texture, thin consistency, cut up food into smaller pieces.<br><br>In a review of the altered diet menu on 12/11/24 at 12:00 PM, Staff C, Cook, and Staff D, Cook, acknowledged that they did not understand the acronyms listed in the different columns of diet texture used by the International Dysphagia Diet Standardization Initiative (IDDSI.) They did not know what SBMM (Small Bite Minced & Moist) meant on the altered menu. They were not sure which column on the menu was related to what they knew as mechanical soft. The Small Bite (SB) column and the Minced and Moist (MM) column required a pureed dinner roll for the bread option on 12/11/24. The SB and MM columns both indicated the lasagna (SBMM) would be small bites, minced and moist.<br><br>On 12/11/24 at 12:15 PM, Staff C served Resident #22 and Resident #3 crispy garlic toast.<br><br>On 12/11/24 at 4:30 PM, the Dietician said that she had talked to the staff about the different IDDSI codes and what those diets looked like, but she also acknowledged that it was often complicated for the staff to know the differences. She said that serving garlic toast to resident on mechanical soft was concerning and they should have known not to serve crisp bread. The Dietician also said that the chunks of green pepper in the pureed eggs was concerning, they should have pureed the eggs until it was smooth, or just not add the green pepper.<br><br>On 12/12/24 at 9:39 AM, The Dietary Manager (DM) said that she was very frustrated with the IDDSI menus and trying to teach staff what foods they could serve on a mechanical soft diet. She said she would reach out to the Dietician and work on finding a solution.<br><br>A facility policy titled: Therapeutic Diets, effective on 10/2024, indicated that the mechanically altered diets, as well as diets modified for medical or nutritional needs would be considered therapeutic diets. The regular menu would be modified by the Registered Dietitian for therapeutic diets with the input from the Dietary Manager. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>41785<br><br>Based on observation, interview and record review the facility failed to ensure a clean, well maintained kitchen area for food preparation, failed to maintain adequate water temperature on the dishwasher, and failed to use proper sanitation and glove use during lunch service. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>In an observation of the kitchen on 12/11 at 11:30 AM, it was discovered that just inside the kitchen, there was a wood counter top with a surface that was peeling off. The kitchen staff said that someone had used a counter top paint, not realizing that the chemical cleaners would cause it to peel. Several of the doors and door frames had chipped and stained paint. The corners of the floors and along the floor base was dirty and stained. The garbage disposal water lines had built up rust and dirt collected around and underneath.<br><br>A thermometer below the dishwasher read 110 degrees Fahrenheit (F). Staff D, Dietary Aide acknowledged that the target temperature was 120 but it wasn't getting any higher than 118 F. She said that they had a new water heater in the basement but the maintenance man failed to get it hooked up and he had been terminated. A review of the temperature log posted on the refrigerator showed that the temperatures for the month of December, logged three times a day, on just one occasion had gotten up to 120 degrees F.<br><br>On 12/11/24 at 11:30 AM, kitchen staff prepared the lunch and a pan of garlic toast was on a cookie sheet, on the top of the stove. Staff C prepared the pureed meals, beginning with the broccoli. As he scooped the vegetable out of the pan and into the blender, he laid the utensil on the counter without a barrier, where there were visible crumbs.<br><br>On 12/11/24 at 12:15 PM, Staff C donned disposable gloves, touched several surfaces, utensils and bread bag, then with the same gloved hands retrieved a piece of bread from the bag. As he prepared a peanut butter sandwich, he set the bread on the counter without a barrier.<br><br>On 12/12/24 at 9:39 AM, the Dietary Manager (DM) said that she was aware of the temperatures on the dishwasher not getting above 118 degrees F most of the time. The maintenance man left abruptly and didn't get the new water heater hooked up. She acknowledged the need for paint on the doors and walls, and the need to deep clean stained corners on the floors. The DM said that she hadn't noticed paint chipping off of the wood counter and said that they have stainless steel tables that could be installed. The DM said that the glove use and putting the bread on the counter without barrier are concerns with infection control and she would reeducate staff.<br><br>According to the facility policy titled: Handwashing/Hand Hygiene, last revised 10/2022, Staff would follow the Handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The use of gloves did not replace Handwashing/hand hygiene. |

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| F 0838<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.<br><br>41537<br><br>Based on record review and staff interview the facility failed to create and implement a facility assessment timely once identified it did not have one in place to ensure residents needs are met. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>Record review of a document titled Self-Identification Form and Correction Form dated 12/10/24 but the Director of Nursing (DON) revealed on 11/22/24 she identified the facility does not have a facility assessment. She documented it would be completed by 12/31/24.<br><br>During an interview on 12/12/24 at 12:44 PM with the DON revealed the facility did not have a facility assessment completed but hopes to by the end of the month. |

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| F 0865<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>41537<br><br>Based on record review, staff interview, and policy review the facility failed to develop, implement, and maintain an effective, comprehensive, data-driven Quality assurance and performance improvement (QAPI) program that focused on indicators of the outcomes of care and quality of life timely. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>Record review of a document titled Self-Identification Form and Correction Form dated 12/10/24 by the Director of Nursing (DON) revealed on 11/22/24 she identified the facility does not have a QAPI program in place and on 1/7/24 the facility will begin to meet monthly.<br><br>During an interview on 12/12/24 at 12:32 PM with the Director of Nursing (DON) revealed she started her position in November 2024 and had a large binder with a QAPI plan but no one is completing it at this time. |

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| | 165426 | A. Building<br>B. Wing | 12/17/2024 |

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| F 0867<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>41537<br><br>Based on record review, staff interview, and policy review the facility Quality Assurance and Performance Improvement (QAPI) program failed to be implemented resulting in no monitoring of: facility adverse events, program systematic analysis and systemic actions, program activities, and quality assessment and assurance. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>Record review of a document titled Self-Identification Form and Correction Form dated 12/10/24 by the Director of Nursing (DON) revealed on 11/22/24 she identified the facility does not have a QAPI program in place and on 1/7/24 the facility will begin to meet monthly.<br><br>During an interview on 12/12/24 at 12:32 PM with the Director of Nursing (DON) revealed she started her position in November 2024 and had a large binder with a QAPI plan but no one is completing it at this time. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>46873<br><br>Based on facility record review, staff interview and facility policy review, the facility failed to hold quarterly Quality Assurance Process Improvement (QAPI) meetings for 2024. The facility additionally failed to employ a required Quality Assessment & Assurance (QAA) committee member, a qualified Infection Preventionist, to perform infection control surveillance and report to the governing body. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>On 12/9/24 at 9:29 am, the Interim Director of Nursing (DON) stated the facility did not have an infection preventionist. She stated she is currently enrolled in the course and will be overseeing the role for the facility.<br><br>On 12/10/24, the DON provided a Self-Identification & Correction Form. The form identified the facility had no active QAPI program for Monitoring, Performance Improvement Project (PIP) identification of collaboration between departments to ensure that audits/issues are being taken care of. The form identified this was noted on 11/22/24. It identified monthly meetings would begin in January.<br><br>On 12/11/24 at 8:56 am, the DON stated the facility's administrator had started at the facility in September of 2024 and there has been no formal QAPI program in the facility under his leadership.<br><br>A QAPI binder provided during the survey documented monthly signature sheets for employees in attendance at monthly meetings.<br><br>No signature sheets were provided for January through April. Signature sheets for May, June and July were dated 2023 rather than 2024.<br><br>The first signature sheet provided for 2024 was dated 8/30/24. No designated Infection Preventionist was listed on the signature sheet.<br><br>The second signature sheet provided for 2024 was dated 9/27/24. Neither the Director of Nursing or any nurse was present for this meeting. The Medical Director was noted to have been called an hour after the meeting began.<br><br>The facility policy titled Quality Assessment and Performance Improvement Plan and Program F865, revision date 10/2022 identified the following:<br><br>Point 5:<br><br>a. Develop, implement and maintain an effective, comprehensive, data driven QAPI Program that focuses on indicators of the outcomes of care and quality of life.<br><br>b. Maintain evidence of ongoing QAPI Program which include:<br><br>(continued on next page) |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | i. Reports demonstrating identification ,reporting, investigation, analysis and prevention of adverse events;<br><br>ii. Data collection and analysis at regular intervals; and<br><br>iii. Documentation demonstrating development, implementation and evaluation of corrective actions or performance improvement activities. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>46873<br><br>Based on observations, clinical record review, staff interviews, guidance from the Centers for Disease Control (CDC) and facility policy review the facility failed to follow infection control standards during personal care of a resident (Resident #30) and during medication administration. The facility also failed to properly sanitize the ice machine, develop a water management plan and conduct infection control audits. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) of Resident #30, dated 9/19/24 identified a Brief Interview of Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS documented the resident to be dependent upon staff to perform toileting hygiene. The MDS recorded the resident to always be incontinent of bowel and bladder. The MDS documented the presence of a feeding tube.<br><br>The Care Plan of Resident #30 documented a Focus Area of Enhanced Barrier Precautions in place to decrease transmission of CDC-targeted MDRO's (multi drug resistant organisms), dated 9/23/24. The Care Plan stated this was related to Gastronomy (feeding tube). The Care Plan directed staff to use Personal Protective Equipment (PPE) when providing high-contact resident care activities including changing briefs or assisting with toileting. The Care Plan documented an additional Focus Area requiring assistance with Activities of Daily Living (ADLs) due to amputation of left leg above the knee, revision date 7/2/24. The Care Plan directed staff the resident to be totally dependent for toilet use. The Care Plan documented the resident to be incontinent at all times due to his inability to safely sit on a toilet.<br><br>Observation on 12/9/24 at 10:53 am, Resident #30 was lying in bed. A strong odor of urine was noted in the room. His brief was visibly soaked with urine. At the entrance to his room, an Enhanced Barrier Precautions (EBP) sign was on the wall and a fully stocked isolation cart was at the doorway to the room.<br><br>An article from the CDC dated 6/28/24 titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes documented the following:<br><br>Point 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of Multidrug-Resistant Organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).<br><br>Point 3. Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). Residents are not restricted to their rooms and do not require placement in a private room. Enhanced Barrier Precautions also allow residents to participate in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they 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.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/11/24 at 9:25 am, Staff L, Certified Nurse Aide (CNA) was observed wheeling Resident #30 back to his room following breakfast. At 9:28 am, Staff I, CNA joined Staff L to transfer Resident #30 back to his bed.<br><br>On 12/11/24 at 9:30 am, the State Surveyor knocked and asked permission to enter the room to observe the staff providing care. Resident #30 was in his specialty wheelchair with a full body mechanical lift sling in place under his body. Staff I and Staff L, CNAs, were both wearing gloves and were in the process of attaching the sling loops to the full body lift. No additional PPE was observed.<br><br>At 9:32 am, Staff I removed the disposable bed pad from the resident bed and Staff L placed a new clean bed pad on the bed. The resident was then lowered to the bed and the sling of the full body mechanical lift was disconnected from the lift. At 9:34 am, Staff L reached for a clean incontinent brief which was on the sink vanity at the entrance to the room. Staff I assisted the resident to turn to his right side and Staff L tucked the sling underneath the resident as both staff assisted to lower the resident's pants. Staff I reached to open the tabs on the soiled incontinent brief.<br><br>Still wearing the same gloves, Staff L then opened the nightstand drawer and obtained wet wipes. She used her left hand to assist the resident to stay on his side and took wet wipes from the package with her right hand. She then moved the wipes into her left hand and cleansed the resident's buttocks of stool. She repeated this process multiple times due to the resident being incontinent of bowel. Staff I then began to obtain clean wipes from the package and hand them to Staff L. The package of wet wipes was emptied and Staff L obtained a new package from the nightstand drawer and continued cleansing Resident #30's buttocks. Staff L then tucked the soiled incontinent brief underneath the resident and then removed her gloves and placed them in the trash can. Staff L walked into the bathroom and obtained new gloves and placed them on her hands. Staff L failed to do any hand hygiene. Staff L then tucked the clean incontinent brief under the resident. Both staff then assisted the resident to turn to his left side. Staff I removed the heel protector from the resident's foot, removed the full body lift sling from under the resident and placed it directly on the floor next to the bed. Staff I then reached for the wet wipes from the head of the bed and began to cleanse the resident buttocks from her side. She placed the soiled wipes inside of the soiled brief which was lying on the bed with no barrier. After the resident's buttocks were cleaned, Staff L picked up the trash can off the floor. She held it over the bed and Staff I placed the soiled brief in the trash can. Both staff at this time removed their gloves. Neither staff member performed hand hygiene. Neither staff were observed performing any incontinence cares on the front of Resident #30, only on his buttocks.<br><br>Staff I then secured the clean brief to the resident. She picked up the heel protector from the bed and placed it on the vanity. She then picked up the full body lift sling off of the floor. Staff L moved the bed back into place and obtained a fall mat from across the room. Staff I continued to hold the soiled full body mechanical lift sling in her hands, and picked up the remote control for the bed to lower the bed to the lowest position and raise the head of the bed. Staff L picked up the trash bag from the trash can. Staff I then put the lift sling back onto the floor and walked to the sink and washed her hands. Staff L then pushed the resident's wheelchair to the hallway, and left the room with the trash bag with no hand hygiene witnessed. Staff I put the resident's call light in his reach and picked the soiled lift sling up off the floor. She carried it down the hall and placed it in the laundry barrel and walked down the hall in the opposite direction of the resident's room. Staff L returned to the room with new trash bags and placed a clean trash liner in the trash can. She then washed her hands prior to exiting the room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/11/24 at 9:47 am, Staff L was asked by the State Surveyor if she had received any education from the facility regarding Enhanced Barrier Precautions. She stated she had not. When asked if she was aware of why there was signage and a stocked isolation cart at the doorway to Resident #30's room, she stated she was not aware of the reason for that.<br><br>On 12/12/24 at 10:33 am, the Interim Director of Nursing (DON) stated she would expect staff to wash their hands or use hand sanitizer prior to beginning personal care for a resident. She stated after touching any equipment, etc, gloves should be changed and hand hygiene performed. She stated gloves are not needed to transfer a resident using a lift. Staff should prepare to perform peri cares, then wash hands and place gloves on. She also stated she gave education to the staff the prior evening regarding enhanced barrier precautions and all staff signed a document that they received education and understood. She stated additional staff were educated on the day shift that morning.<br><br>The facility policy titled Perineal Care, revision date 10/2023 documented the following:<br><br>Step 1: Place the equipment on the bedside stand, arrange the supplies so they can be easily reached.<br><br>Step 2: Wash and dry hands thoroughly.<br><br>Step 6: Raise the resident gown or lower the pajamas.<br><br>Step 7: Put on gloves<br><br>Step 10 b (male resident): Wash perineal area starting with urethra and working outward. Continue to wash the perineal area including the penis, scrotum and inner thighs. Do not reuse the same washcloth or disposable wipes to clean the urethra.<br><br>Step 10 f: Instruct or assist the resident to turn on his side with his upper leg slightly bent, if able.<br><br>Step 10 h: Wash the rectal area thoroughly, including the area under the scrotum, the anus and the buttocks.<br><br>Step 11: Discard disposable items into designated containers.<br><br>Step 12: Remove gloves and discard into designated containers. Wash and dry hands thoroughly.<br><br>Step 13: Reposition the bed covers. Make the resident comfortable.<br><br>Step 14: Place the call light within easy reach of the resident.<br><br>Step 15: Return supplies to designated area<br><br>Step 16: Clean the bedside stand<br><br>Step 17: Wash and dry your hand thoroughly.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 41785<br><br>2. On 12/12/24 at 1:20, it was discovered that a sign off sheet hung on the side of the ice machine. The form was titled: Ice Machine Cleaning and Sanitizing; Dietary Weekly Cleaning Log. The most recent time that all the ice was emptied and machine sanitized was 10/14/24. The bucket and scoop last sanitized on 11/8/24. Staff F from housekeeping said he wasn't sure who was responsible to complete the task.<br><br>3. On 12/10/24 at 7:46 AM, Staff A, Certified Medication Aide (CMA) prepared oral medications for an unidentified resident in the dining room. He put the pills in a small cup and filled a glass with water. He then carried the cup of water to the table with his finger inside the cup of water.<br><br>4. On 12/12/24 at 2:20 PM, Corporate Maintenance Manager (CMM) said that he traveled to different facilities to monitor the maintenance departments, and the last time he had been at this facility was the previous week. He said that they had trouble with Maintenance Man (MM) tried on many occasions to direct and teach him, but the monthly checks and documenting just wasn't getting done so they eventually had to let him go. The previous MM told him that he was doing the check, but when the CMM visited the building he found it was not completed.<br><br>When asked about the water born pathogen program and where to find the plan and mapping, the CMM said it could be found in the Maintenance Book or Fire Marshall book. A review of both binders found that the water management forms were in the binder but had not been completed.<br><br>The facility failed to establish and review water system annually and document in the Infection Control Committee minutes. Failed to demonstrate they had taken measures to minimize risk of Legionella and other opportunistic pathogens in the building water system through a documented water management program.<br><br>A facility policy titled; Water Management, Legionella Testing showed that the facility would handle and maintain it's water supply in accordance with recommendations of the CDC (Center For Disease Control), Healthcare Infection Control Practices Advisory Committee and the FDA (Food and Drug Administration.) The community would demonstrate its measures to minimize their risk of Legionella and other opportunistic pathogens in the building water system through a documented water management program. They would complete the review of the water system annually and document in the Infection Control Committee minutes.<br><br>41537<br><br>5. During an interview on 12/12/24 at 12:38 PM with the DON revealed she has completed audits for infection control, including hand washing and Personal Protective Equipment (PPE) applying and removing but is unable to find them. She also informed she would expect routine and random infection control audits be completed to ensure infection control practices are being followed by all staff. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Implement a program that monitors antibiotic use.<br><br>41537<br><br>Based on record review, staff interview and policy review the facility failed to ensure an antibiotic stewardship program was in place for 33 of 33 residents. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>Record review of Resident #8 Orders on her Medication Administration Record (MAR) on 12/11/24 revealed she is currently taking an antibiotic, Nitrofurantoin 100 milligrams (mg) twice a day for UTI prophylaxis (an attempt to prevent disease) she started on 12/3/24.<br><br>Request was made on 12/12/24 at 12:29 PM to review resident antibiotic tracking logs since January 2024 to December 2024 and the facility was unable to provide the requested documentation.<br><br>During an interview on 12/12/24 at 12:32 PM with the Director of Nursing (DON) revealed she started her position in November 2024 and was unable to locate tracking of antibiotic usage for residents from January 2024 to November 2024. She then informed she had a plan in place to start tracking but it will not start until January 2025 and nothing had been tracked for December 2024 thus far. She revealed she write down a few residents that had infections in November 204 but did not verify if lab cultures were completed or McGreers criteria was met (A set of surveillance definitions for infections in long-term care facilities. The criteria are used to identify infections by considering the clinical presentation, microbiologic and radiological information, and any other relevant findings).<br><br>Review of the facilities policy dated 12/2024, Infection Prevention and Control Program, instructed a procedure to follow for tracking infections, however the facility was unable to provide documentation it was completed. |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>41537<br><br>Based on staff interviews, job description, and policy review the facility failed to employee a qualified person to serve as the Infection Preventionist (IP) for the facility. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>During and interview on 12/09/24 at 9:29 AM with the Administrator revealed the facility did not have an IP employed at the facility but the Director of Nursing (DON) is enrolled in a course.<br><br>During an interview on 12/12/24 at 12:44 PM with the DON revealed she does not have and IP certification but is in a class.<br><br>Record review of the facilities job description, Infection Preventionist dated 12/2024 instructed the following:<br><br>The employee holding this position must be able to perform these tasks satisfactorily:<br><br>a. Develops and implements an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections in order to provide a safe, sanitary, and comfortable environment.<br><br>b. Establishes facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors.<br><br>c. Develops and implements written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control.<br><br>d. Oversees the facility's antibiotic stewardship program.<br><br>e. Oversees resident care activities that increase risk of infection (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, point-of-care blood testing, and medication injections).<br><br>f. Leads the facility's Infection and Prevention Control Committee. Develops action plans to address opportunities for improvement.<br><br>Record review of the facilities policy, Infection Prevention and Control Program dated 12/2024 documented:<br><br>The Infection Prevention and Control Program is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785<br><br>Based on record and policy review, and interview the facility failed to provide pneumococcal vaccine as requested for 1 of 5 residents reviewed. Resident #34 consented to receive the vaccine and the facility failed to follow through and provide the immunization. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated [DATE], Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability.) She was independent with toileting, dressing, transfers and eating.<br><br>The Care Plan updated on 10/3/24, showed that Resident #34 was receiving radiation/chemotherapy treatments related to breast cancer.<br><br>According to the Vaccine tab in electronic chart, Resident #34 was given an influenza vaccine on 10/23/24.<br><br>A Pneumococcal Vaccine Informed Consent dated 9/11/24 at 9:56 AM, signed by the Power of Attorney (POA), indicated that they received information and gave consent to receive the vaccine.<br><br>On 12/12/24 at 2:30 PM, the Director of Nursing (DON) said that any vaccines received at the facility would be documented in their record. She was not at the facility in September and didn't know why the pneumococcal vaccine had not been administered to Resident #34.<br><br>A facility policy titled; Pneumococcal Vaccine, last revised 10/2024 showed that residents would be offered the pneumococcal vaccine to aid in preventing pneumococcal infections. Prior to admission, resident would be assessed for eligibility to receive the pneumococcal vaccine and when indicated would be offered the vaccination unless medically contraindicated or the resident had already been vaccinated. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785<br><br>Based on interview, record and policy review, the facility failed to provide the Covid-19 immunization booster as requested for 2 of 5 residents. Resident's #20, and #30 signed consent agreements to get the Covid-19 booster, the facility failed to follow through and provide those immunizations. The facility reported a census of 33 residents.<br><br>Findings include:<br><br>1) According to the Minimum Data Set (MDS) dated [DATE], Resident #20 did not have a Brief Interview for Mental Status (BIMS.) assessment because she was rarely understood. She required substantial assistance with eating, sit to stand, toilet transfers and was totally dependent for hygiene and dressing. The MDS showed that her Covid-19 vaccination was up to date.<br><br>The Immunization tab for Resident #20, showed that Resident #20 received dose 2 of the Covid-19 vaccine which was administered on 4/8/21.<br><br>The care plan for Resident #20, updated on 10/13/24, showed that she was at risk for injury due to impaired safety awareness. She had chronic pain related to osteo arthritis and used antianxiety medication related to dementia. She was at risk for alterations in nutritional status and had diagnoses that included chronic kidney disease, heart failure, and history of Covid-19.<br><br>A Resident Consent Form for Covid-19 Vaccine (RCFCV) dated 5/13/24, showed that a resident representative gave verbal permission for the resident to get the vaccine.<br><br>2) According to the Minimum Data Set (MDS) dated [DATE], Resident #30 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits.) The resident was totally dependent on staff assistance for toileting hygiene, dressing, personal hygiene and chair to bed transfers. The resident was on a mechanically altered diet and a feeding tube for nutrition.<br><br>The care plan last updated on 9/23/24, showed that Resident #30 had impaired communication and said very few words. He required assistance with Activities of Daily Living (ADLs) related to an amputation above the left knee and he was bedfast most of the time. He required assistance with eating pureed foods, as well as tube feedings during the day.<br><br>The Immunization tab in the electronic chart lacked documentation of a Covid-19 immunization.<br><br>A RCFCV form showed that on 5/13/24, the Power of Attorney (POA) gave permission via telephone, to administer the Covid-19 vaccine to Resident #30.<br><br>On 12/12/24 at 2:30 PM, the interim Director of Nursing (DON) acknowledged that the facility did not have any evidence that the Covid-19 booster had been offered to residents. She thought that maybe the pharmacy would have come to the facility to provide those in the fall, but according to the resident files, that had not happened in 2023 or 2024.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165426 | A. Building<br>B. Wing | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspire of Perry | 2625 Iowa Street<br>Perry, IA 50220 |

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 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | According to a facility policy titled: Vaccination of Residents, Including Influenza, Pneumococcal, RSV and COVID-19, effective 10/2024, residents would be offered flu, pneumovax and COVID-19 vaccinations per CDC (Centers for Disease Control) and CMS (Center for Medicaid and Medicare Services) guidelines, based upon availability to the community. The community would offer the COVID-19 vaccination when available to the community. |