STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165445	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and resident and staff interview, the facility failed to include a resident or resident representative in care conferences for 1 of 1 resident reviewed (Resident #20). The facility reported a census of 20 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #20 revealed a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The resident had diagnoses of stroke, hemiplegia (paralysis on 1 side) or hemiparesis (weakness on 1 side), bipolar disorder, and cognitive communication deficit. In an interview on 3/11/24 at 11:26 AM, Resident #20 reported she didn't know anything about care conferences, had never been invited to one. The Care Conference Note on 10/27/23 at 3:23 PM written by Staff H, Social Services Designee, lacked information that the resident or resident representative was invited to the care conference. In an interview on 3/13/24 at 10:49 AM, Staff H, Social Service Designee, reported that she started in this role 2 months ago, prior to this, the previous Director of Nursing (DON) managed care conferences and kept a binder of letters sent to families inviting them to care conferences. When asked if the resident and her representative should be invited to care conferences, Staff H agreed.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to provide written notice, including the reason for a room change, before the resident's room was changed for 1 of 1 resident reviewed (Resident #19). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #19 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS revealed the resident had diagnoses of anxiety, depression, and schizophrenia. The Census information revealed the resident changed rooms on 2/15/24. The Health Status Note on 2/16/24 at 00:29 AM revealed resident moved rooms, tolerating new room. The Clinical Record lacked further information related to the room change, including written notification to the resident prior to the room change including the reason for the room change. In an electronic mail (email) on 3/18/24 at 3:37 PM, the Administrator reported the Progress Note on 2/26/24 was the only documentation. In an interview on 3/19/24 at 4:15 PM, the Administrator reported that the resident changed rooms because the facility had a new admission who was a female resident and Resident #19 needed to change rooms to accommodate the new resident. The Notification of Room Change Policy dated February 2015 directed form completion directions, in pertinent part: 1. Enter the resident/patient name, physician, and medical record number at the bottom of the form. 2. Enter the date and time of the room change. Indicate if the room change occurred in the AM or PM. 3. Enter the room number moving from and the room number moving to. 4. Enter the date the resident/patient was notified. If unable to notify, explain the reason (e.g., comatose). 5. Enter the date the family or responsible party was notified, if indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Enter the date the resident/patient ' s new roommate was notified. 7. Briefly describe the reason for the room change. 8. Sign and date the form. 9. Provide a copy of the form to the resident/patient and/or family/responsible party.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0584 Level of Harm - Minimal harm or potential for actual harm 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. 44475 Based on observation, facility policy, and staff interview, the facility failed to clean windows or repair window trim in a resident's room (Resident #20), clean windows in the dining room, or clean and repair kitchen windows. The facility reported a census of 29 residents. Findings include: In an observation on 3/11/24 at 11:26 AM, the window in Resident #20's room had thick, brown cobwebs adhered to the window, a pile of leaves 4 inches high and 8 inches long in between the window panes, and a piece of window trim that had pieces falling off with a 10 inch long section of exposed wood. The outer part of the window unit had a screen in place and a storm partially covering the screen. In a concurrent interview and observation on 3/14/24 at 8:20 AM, when asked about the amount of flies in the kitchen, Staff F, Cook, pointed out a window in the kitchen with the screen not secured which created a 0.5 inch gap. Staff F and Registered Dietician (RD) reported this was a point of entry for flies. The other window in the kitchen had loose brown debris in the inner sill and dry white spots. In an observation on 3/14/24 at 11:56 AM, the same window in the kitchen had the same gap. Observation on 3/14/24 at 1:17 PM of a window in the kitchen was open and blowing into the kitchen, the window interior was dirty as was the lower rim of the window. In an interview with the Administrator and Staff D, Maintenance Director, on 3/13/24 at 10:49 AM, when asked about Resident #20's window, Staff D, maintenance, reported that windows are cleaned twice per year in the spring and fall. The area where the resident's room is located has issues with wind. The Window Inspections document with a next due date of April 2024 revealed that this facility inspection task occurred every 3 months and was not assigned to a specific staff person. The window inspection task directed, in pertinent part, to ensure screens are in place and in good repair and check windows for breakage and cracks, replace as needed. The Environmental/Plant Operations Policy dated March 2016 directed: 1. The facility strives to protect the residents, staff, and visitors from insects and other pests by controlling infestation through contracts with outside pest control agencies. It is the responsibility of all staff members to detect and report immediately the presence of pests to their supervisor. 2. Procedure to contract with a pest control agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Evaluate effectiveness of services and contact pest control agency if additional services are needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, staff interviews, and facility policy, the facility failed to provide a bed hold notice to 1 of 1 residents and or the resident's responsible person, when resident transferred out of the facility (Residents #25). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #25 documented diagnoses of traumatic brain injury, seizure disorder, anxiety and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Review of Progress Note dated 2/29/24 at 6:05 PM, revealed Resident #25 has been transferred to the hospital. Review of Progress Note dated 2/29/24 at 8:53 PM, revealed Resident #25 has been admitted to the hospital. Review of MDS list revealed MDS dated [DATE] labeled discharged assessment return anticipated. Review of Resident #25 ' s medical chart lacked documentation of a bed hold completed by resident or resident representative. The facility's undated Bed Hold Policy revealed the facility will hold a bed while the Resident is absent from the center for therapeutic leave or temporary stays in an acute care hospital. You must request any desired bed-hold within 24 hours of receiving the notice of discharge or transfer. Interview on 3/13/24 at 3:00 PM with the DON revealed the expectation would be to do a bed hold anytime a Resident would discharge from the facility to the hospital or within twenty four hours per their policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to perform elopement risk assessments for 1 of 2 residents reviewed (Resident #21). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 6 which indicated severely impaired cognition. The MDS revealed the resident had diagnoses of anxiety, depression, bipolar disorder, psychotic disorder, schizophrenia, post traumatic stress disorder, mild intellectual disabilities, and visual hallucinations. The resident had a wander/elopement alarm used daily. The Elopement Risk Assessments performed showed the resident was not at risk of elopement: 1. 5/28/22 2. 7/1/22 3. 8/10/22 4. 1/25/24 The Health Status Note on 1/12/23 at 9:19 PM revealed, in pertinent part, resident walked out the facility unassisted. Wander guard alarmed and staff went out to get resident. The Elopement Risk Assessment performed 11/12/23 showed the resident was at risk for elopement. In an interview on 3/18/24 at 3:37 PM, the Director of Nursing (DON) and Regional Nurse Consultant (RNC) reported that the resident's wanderguard order started 12/8/22 and despite some unknown reasons why the order has been changed, the wanderguard continues to be in place. When asked the reason the resident did not have elopement risk assessments performed as part of her comprehensive quarterly assessments, the RNC reported that the content of the elopement risk assessment was lacking to support an overall perspective of the resident's risk for elopement. The RAI (Resident Assessment Instrument)/Care Planning Management Policy dated October 2023 directed, in pertinent part: 1. It is the practice of this facility to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. 2. Identify resident's individual needs and care requirements. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 1304 South Market, Lake Park, IA 51347	

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Assure an interdisciplinary team assesses the emotional, psychological, mental, and physical needs of each resident. 4. Assure all residents are reviewed and reassessed based on their individual needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to accurately complete Minimum Data Set (MDS) assessments for 2 of 12 residents reviewed (Resident #19 and #29). The facility reported a census of 29 residents. Findings include: 1. The MDS dated [DATE] for Resident #19 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS revealed the resident had diagnoses of anxiety, depression, and schizophrenia. The MDS question did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry was answered no. The MDS revealed the resident re-entered the facility on 2/1/24 and was originally admitted to the facility on [DATE]. The resident had a diagnosis of hip fracture. The Major Injury Determination Form signed by a physician on 1/15/24 revealed that on 1/13/24 the resident reported he fell going to the toilet and that the physician attested that the sustained fracture was a major injury. 2. The MDS dated [DATE] for Resident #29 revealed a BIMS of 15 which indicated intact cognition. The resident had diagnoses of coronavirus and chronic obstructive pulmonary disease (COPD). The MDS revealed the resident was discharged from the facility on 2/17/24 to a short-term general hospital. The Health Status Note on 2/13/24 at 3:49 PM revealed in pertinent part, call placed to home health regarding orders for resident to have home health assistance. The RAI (Resident Assessment Instrument)/Care Planning Management Policy revised October 2023 directed, in pertinent part: 1. It is the practice of this facility to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. 2. The MDS Coordinator reviews documentation in the medical record and enters appropriate information on the MDS. 3. The IDT (Interdisciplinary Team) members discuss and then document the most accurate, consistent coding information on the MDS. 4. Documentation is reviewed/validated by the facility nursing leadership. In an interview on 3/20/24 at 2:23 PM, the Director of Nursing (DON) reported that there was a newer staff person in the MDS nurse role and that as a result of the survey, would be getting MDS training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, The Preadmission Screening and Resident Review (PASRR) and Level of Care Screening Procedures for Long Term Care Services Provider Manual, facility policy, and staff interview, the facility failed to develop a care plan with required PASSR services and supports for 1 of 1 resident reviewed (Resident #26), failed to develop a care plan with therapy discharge recommendations for 1 of 1 resident reviewed (Resident #5), and develop a care plan for high risk medications for 2 of 5 residents reviewed (Residents #20 and #27). The facility reported a census of 29 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #26 revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The resident had diagnoses of depression, bipolar disorder, and multiple sclerosis. The resident was admitted to the facility on [DATE] and assessment reference date for the completion of the MDS was 2/22/24. The MDS question, is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, was answered no. The (PASSR) Level II dated 2/22/24 directed, in pertinent part, that the resident will need the following specialized services: 1. Psychiatric medication management by a psychiatrist or a psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services). 2. The individual needs to designate [NAME] of Attorney for Healthcare and Financial matters in order to serve as substitute decision makers in the event of incapacity, assist with decision making, and support the individuals health, resource management, and/or safety. a. Supportive counseling from NF (nursing facility) staff. b. Obtain archived psychiatric/behavioral health treatment records to clarify history and then make those past records available to all medical and behavioral health service providers. 3. What services or supports will you need outside of a nursing facility if you remain in or return to the community (for example, home or a residential setting)? At this time you require 24 hour support in nursing facility level of care. Due to your age, if you should experience an increase in your independence your nursing facility should work with you to transition to a lower level of care. The resident's Care Plan did not contain any of the specialized services listed in the PASSR Level II. The PASRR and Level of Care Screening Procedures for Long Term Care Services Provider Manual revised 2/8/23 directed that the care plan must plan for all specialized and rehabilitative services and supports identified in the SOF (Summary of Findings). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/20/24 at 11:42 PM, the Regional Nurse Consultant (RNC) reported that she was aware that when a resident has a PASSR Level II, the recommendations listed should be placed on the resident's care plan. 2. The MDS dated [DATE] for Resident #5 revealed a BIMS of 15 which indicated intact cognition. The resident had diagnoses of malnutrition, anemia, and chronic pain. On 2/7/23, the resident was discharged from Physical Therapy (PT) with walk to dine program to be performed 3 times per week. On 4/19/23, the resident was discharged from Occupational Therapy (OT) with a walk to dine program to be performed 3 times per week and HEP (home exercise program) for LUE (left upper extremity). The resident's care plan did not contain either the walk to dine program or the HEP. In an interview on 3/18/24 at 3:32 PM, the Director of Nursing (DON) and Regional Nurse Consultant (RNC) reported that the resident's walk to dine program and HEP should be on her care plan. The RAI (Resident Assessment Instrument)/Care Planning Management Policy dated October 2023 directed in, pertinent part that: 1. If modifications, deletions, or additions are necessary to the comprehensive care plan, changes should be made at the time of occurrence. 2. Care plans are to be accessible for clinical staff in order to facilitate care plan interventions or to update as indicated due to resident condition change. 3. The MDS dated [DATE] for Resident #20 revealed a BIMS score of 12 which indicated moderately impaired cognition. The resident had diagnoses of stroke, hemiplegia (paralysis on 1 side) or hemiparesis (weakness on 1 side), bipolar disorder, and cognitive communication deficit. In the 7 days prior to the MDS assessment, the resident took insulin and opioid medications. The Medication Administration Record (MAR) for March 2023 revealed an order for tramadol (opioid pain medication) tablet 50 MG (milligram). Give 1 tablet by mouth TID (three times per day) PRN (as needed). Start Date 11/1/23. The resident had 15 doses of tramadol from 3/1/24 to 3/20/24. The resident's care plan did not contain side effects of insulin or tramadol. In an interview on 3/21/24 at 1:30 PM, the DON agreed that side effects of insulin and tramadol should be listed on the resident's care plan. 4. The MDS dated [DATE] for Resident #27 revealed a BIMS of 6 which indicated severely impaired cognition. The resident had a diagnosis of non-Alzheimer's dementia. The Provider Order signed by a Psychiatric-Mental Health Nurse Practitioner-Board Certified (PHMNP-BC) on 1/12/24 directed that the resident started taking melatonin 3 mg by mouth at bedtime. The care plan for Resident #27 did not contain use of melatonin and potential side effects. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/21/24 at 1:30 PM, the the DON agreed that side effects of melatonin should be listed on the resident's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, staff interview, and facility policy review the facility failed to revise and update the care plan to include fall and wound interventions for 3 of 12 residents reviewed (Residents #3, #10, and #24). The facility reported a census of 29 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #10 documented diagnosis of coronary artery disease, hypertension and thyroid disorder. The MDS showed a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Review of clinical record showed Resident #10 has a wound to the left buttock. Review of the care plan for Resident #10 with a target date of 5/20/24 lacked information regarding pressure reducing devices to the recliner and wheelchair. 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #24 documented diagnosis of Alzheimer ' s Disease, hypertension and hyperlipidemia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. Review of the clinical record showed Resident #24 had an unwitnessed fall on 11/9/23 at 8:15 PM. Review of the care plan for Resident #24 with a target date of 5/29/24 lacked an intervention for the fall on 11/9/23. On 3/13/24 at 11:01 AM the DON stated that there was no intervention put into place for this fall. Review of facility policy titled Care Planning Management undated revealed if modifications, deletions, additions are necessary, changes should be made at the time of occurrence. Modifications are made by resolving the item in the electronic medical record and adding the new information. Care plans are to be updated in an acute situation when identified, such as falls, falls with injury, new skin alterations, worsening skin conditions, behaviors, resident events, weight loss, infections, uncontrolled pain, allegations of abuse and other concerns that involve resident care/condition. These updates are to be prompt upon notification and should be reviewed and implemented in the daily clinical meeting and as they occur. Interview with DON on 3/13/23 at 3:00 PM revealed the expectation would be that the nurse ' s should place interventions in place at the time of the incident. 44475 3. The Minimum Data Set (MDS) dated [DATE] for Resident #3 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The resident had diagnoses of schizoaffective disorder, bipolar type, diabetes mellitus, multiple sclerosis, anxiety, and depression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165445	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/13/24 at 12:25 PM, the Director of Nursing (DON) reported the resident's superior abdominal wound started on 1/4/24. The Health Status Note on 1/4/24 at 11:31 PM revealed resident was seen on ET (enterostomal) wound nurse rounds. Continue current Ostomy regimen with addition of ostomy barrier strips. Recommendations faxed to provider. The Care Plan intervention dated 3/8/24 was for BID (twice daily) dressing changes. In an interview on 3/20/24 at 4:56 PM, the Director of Nursing (DON) reported that she would expect a resident's care plan to show changes in their condition. The RAI (Resident Assessment Instrument)/Care Planning Management Policy dated October 2023 directed in, pertinent part that: 1. If modifications, deletions, or additions are necessary to the comprehensive care plan, changes should be made at the time of occurrence. 2. Care plans are to be accessible for clinical staff in order to facilitate care plan interventions or to update as indicated due to resident condition change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165445	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to perform a recapitulation of a resident's stay at the facility at the time of discharge for 1 of 1 resident reviewed (Resident #29). The facility reported a census of 29 residents. Findings revealed: The Minimum Data Set assessment dated [DATE] for Resident #29 revealed a BIMS of 15 which indicated intact cognition. The resident had diagnoses of coronavirus and chronic obstructive pulmonary disease (COPD). The Discharge Summary on 2/17/24 at 9:40 AM revealed resident discharged from facility to home, transportation provided by daughter. All belongings sent with resident. Future appointments and paper work sent along with resident inhalers, nebulizer treatments, and ATB (antibiotic) for dentist appointment also sent with res. In a concurrent record review and interview on 3/18/24 at 1:35 PM, the Director of Nursing (DON) and Regional Nurse Consultant (RNC) reviewed the Progress Note for the resident's discharge and reported they were unable to find additional information in the boxes of medical records in the DON's office, that they would expect more information to be included in the resident's record, that if a paper copy was used it would be scanned into the Electronic Health Record (EHR). The Discharge Plan/Transfers Policy dated October 2023 and the Admission and Discharge Process Policy date March 2016 did not include direction on what criteria to include in a recapitulation of a resident's stay at the facility when they are discharged .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to assess, obtain provider orders, or treat an open wound following provider order for 1 of 1 resident reviewed (Resident #3). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #3 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The resident had diagnoses of schizoaffective disorder, bipolar type, diabetes mellitus, multiple sclerosis, anxiety, and depression. In an interview on 3/13/24 at 12:25 PM, the Director of Nursing (DON) reported the resident's superior abdominal wound started on 1/4/24. The Health Status Note on 1/4/24 at 11:31 PM revealed resident was seen on ET (enterostomal) wound nurse rounds. Continue current Ostomy regimen with addition of ostomy barrier strips. Recommendations faxed to provider. The Progress Note on 2/1/24 revealed that a Wound Ostomy Continence Nurse (WOCN) noted the wound onset 2 weeks ago. The Clinical Record lacked assessment, physician notification, or provider order of the resident's abdominal wound. The January 2024 Treatment Administration Record (TAR) lacked any wound treatment to the resident's abdominal wound. The Clinical Record lacked weekly assessments of the abdominal wound since January 2024. The WOCN documentation on 2/1/24, 2/15/24, or 2/21/24 did not contain a provider signature. The WOCN visit recommendations or orders not put into TAR for wound care changes: 2/1/24, 2/15/24, 3/13 visit. As a result, the resident had: 1. Mupirocin applied 5 times after the 3/13/24 order to discontinue topical treatment. 2. Triad applied 2 times after topical care was discontinued after the 2/15/24 visit. In an interview on 3/21/24 at 1:34 PM, the Director of Nursing (DON) reported that she would expect weekly comprehensive wound assessments and that they should be readily accessible by all nursing department staff, that all treatment orders should be signed by a physician before implementing, and that these orders should be followed. When asked about the order process with the WOCN, that the provider signs the WOCN recommendation to make that an order, the DON agreed and reported that there would be no other location for a provider order in the resident's clinical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/13/24 at 2:49 PM, Staff S, reported she would expect residents to have a complete medical record with assessments and orders. Staff S reported that twice in treating this resident, she has reviewed the resident's wound treatment orders in her Electronic Health Record (EHR) and they were outdated by 2-3 weeks. Staff S reported that her process is that the paper sheet she leaves with the facility is uploaded into the resident's EHR. The Skin Management Standard dated October 2023 directed, in pertinent part: 1. It is imperative that a system be in place to document all assessments, treatments, interventions, progress of healing and outcomes. 2. The nurse that evaluates the resident, based on the findings of the staff, will document the assessment in the electronic medical record and will notify the wound care nurse, physician, and responsible party of the condition. Assess the entire resident, not just the wound: b. Consider all factors that can influence healing, 1. Overall physical health - history and physical examination 2. Psychological concerns 3. Determine Etiology 4. Pain 5. General health 6. Nutrition 7. Environmental factors 8. Equipment factors/tubing c. Focus on local wound bed 1. Location/etiology 2. Dimensions/size (length, width, depth) 3. Tunneling/undermining 4. Appearance of wound base 5. Wound edges 6. Peri wound 7. Exudate/drainage (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Staging/tissue involvement 3. The wound will be assessed at least weekly by a licensed nurse and the Director of Nursing will participate in weekly wound rounds. 4. Any change in treatment protocols, interventions and/or monitoring will be communicated to the resident ' s physician and order(s) obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, resident and staff interview, the facility failed to provide services recommended by therapy at discharge for 1 of 1 resident reviewed (Resident #5). The facility reported a census of 29 residents. Findings include: The Minimum Data Set assessment dated [DATE] for Resident #27 revealed a BIMS of 6 which indicated severely impaired cognition. The resident had a diagnosis of non-Alzheimer's dementia. In an interview on 3/11/24 at 12:45 PM, the resident reported that she had Physical Therapy (PT) until around the time she went on hospice and didn't get set up with the discharge exercise program PT wanted her do after she was discharged from PT. The resident reported that she goes to a group fitness class now. The resident reported that she hopes and prays she can walk again. The resident was discharged from PT on 2/7/23 with a program to walk to dine 3 times per week and was discharged from Occupational Therapy (OT) on 4/19/23 with a walk to dine program 3 times per week as well as a HEP (home exercise program) for LUE (left upper extremity). PT and OT did not recommend a restorative program at discharge. The Clinical Record lacked documentation that the resident refused or performed the walk to dine program 3 times per week or the HEP. In an interview on 3/18/24 at 3:32 PM, the Director of Nursing (DON) and Regional Nurse Consultant (RNC) reported that documentation of the resident's walk to dine program and HEP was not on paper and should be in the Electronic Health Record (EHR) in the task section for Certified Nurse Assistants (CNA) to chart on. The Guide to Successful Restorative Programs dated 2018 revealed in pertinent part, that potential candidates for restorative program decision making tool question, can a resident's needs be met by standard nursing care planning and interventions. If this questions was answered no, then a restorative therapy program was appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status for 4 of 4 residents reviewed (Residents #7, #11, #27, and #28). The facility reported a census of 29 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #27 revealed a Brief Interview of Mental Status (BIMS) score of 6 which indicated severely impaired cognition. The resident had diagnoses of renal insufficiency, renal failure, ESRD (end stage renal disease), heart failure (heart muscle can't pump enough blood to meet the body's needs for blood and oxygen causes shortness of breath and fatigue), non-Alzheimer's dementia, anxiety, depression, bilateral hearing loss, and dysphagia (difficulty swallowing foods or liquids). The resident had a loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a prescribed weight loss program. The Weight Log revealed, in pertinent part: 1. The resident weighed 195.4 pounds (lbs.) on 11/1/23. 2. The resident weighed 190 lbs. on 11/4/23. 3. The resident weighed 171.4 lbs. on 11/20/23. 4. The resident weighed 164.2 lbs. on 2/5/24. 5. The resident weighed 158.8 on 3/11/24. The Nutrition Risk assessment dated [DATE] signed by Staff N, Registered Dietician (RD) revealed, in pertinent part, that the resident had a weight loss of > (greater than) 5% in 1 months; >7.5% in 3 months; >10% in 6 months. Progress Notes revealed, in pertinent part: 1. Post Fall Evaluation on 2/17/24 at 5:14 PM, recent weight loss: no. 2. The next Progress Note related to the resident's weight loss occurred 3/8/24 at 3:44 PM, noted to be have a weight loss of 10 LB in 60 days, physician notified per fax (facsimile). The Clinical Record lacked any other documentation of physician notification of the resident's weight loss. In an interview on 3/13/24 at 10:49 AM, when asked if the resident had a significant weight loss that should have been addressed sooner than 3/8/24, the Regional Nurse Consultant (RNC) agreed. The Nutrition and Weight Management Standard Policy dated August 2021 directed, in pertinent part: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Suggested parameters for evaluating significance of unplanned and undesired weight loss are: 6 month interval greater than 10% was a severe loss. 2. If a resident triggers a weight loss, the Director of Nursing (DON) will run a Weight Variance Report to see all triggered weights. Process will then be determined as to: a. RD consultation. b. MD (medical doctor) notification. c. Family notification. d. New orders. e. Medications review. f. Weights more frequently obtained. g. Care plan updates. h. MDS updates. 2. The MDS dated [DATE] for Resident #7 revealed a BIMS of 10 which indicated moderately impaired cognition. The resident had diagnoses of traumatic brain dysfunction, hemiplegia (paralysis) affecting her left side, bipolar disorder, and post traumatic stress disorder. Review of the resident's weight log revealed resident weighed: 1. 182.6 Lbs. (pounds) on 3/4/24 at 5:21 PM. 2. 275.4 Lbs. on 2/5/24 at 3:23 PM. As of 3/20/24 at 11:05 AM, the resident's Clinical Record did not include that the resident was re-weighed or Progress Notes related to the 92.8 lbs. weight discrepancy. In an interview on 3/13/24 at 10:49 AM, the DON reported she would expect nurses to clarify large weight discrepancies. In an interview on 3/13/24 at 2:10 PM, the RNC reported that the scale was moved from the facility during a recent evacuation and was calibrated per manufacturer's directions when the scale was moved back to this facility. The Nutrition and Weight Management Standard Policy dated August 2021 directed, in pertinent part: 1. If a resident triggers a weight loss or gain, the DON will run a Weight Variance Report from PCC (Point Click Care) to see all triggered weights. 2. Process will then be determined as to re-weight indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49056 3. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #11 documented diagnoses of seizure disorder, traumatic brain injury, bipolar disorder and psychotic disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Review of Resident #11's clinical record reviewed the following information: On 12/18/2023, the resident weighed 167.2 pounds (lbs). On 1/15/2024, the resident weighed 156.2 pounds which is a -6.58% Loss. Review of Resident #11' s weights showed the last weight taken on 1/15/24 was 156.2 lbs. There were no weights taken after this date. Review of Resident #11' s MDS dated [DATE] revealed on Section K 0300, weight loss, was coded 2 for yes, not physician prescribed weight loss regimen. Review of Resident #11' s Care Plan with a target date of 5/29/24 lacked information regarding the significant weight loss or interventions in place to prevent further weight loss. Review of Resident #11' s Dietary Progress Note on 2/22/24 revealed weight is down 6.6% in 30 days which is a significant weight loss. 4. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #28 documented diagnoses of Alzheimer's Disease, renal insufficiency, hyperlipidemia and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Review of Resident #28' s clinical record reviewed the following information: On 2/9/24, the resident weighed 149 lbs. On 3/2/2024, the resident weighed 134.2 lbs which was a -9.93% Loss. Review of Resident #28' s weights showed the admit weight as 149 lbs on 2/9/24, the next weight taken on 3/2/24, there were no weights taken weekly per facility policy. Review of Resident #28' s Care Plan with a target date 5/29/24 lacked information regarding the significant weight loss or interventions in place to prevent further weight loss. Review of facility provided policy titled Nutrition and Weight Management Standard dated August 2021 revealed the following: Significant unchanged weight loss of more than 5% in one month, 7-1/2% in three months, or 10% in six months or underweight status of more than 20% below IBW or UBW should be addressed on the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident' s physician and the consultant dietitian are notified. The resident representative is notified. Weights will be monitored on a routine basis, monthly or weekly, upon admission, and/or as directed by physician and/or clinical status of residents. All new admissions will be weighed weekly times four weeks. Residents are weighed at least monthly by the weight team/person designated unless the need for more frequent weights is determined by the physician, nursing staff, or dietary manager.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to notify a physician for evaluation of weight loss for 2 of 4 residents reviewed (Residents #11, #27). The facility reported a census of 29 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #27 revealed a Brief Interview of Mental Status (BIMS) score of 6 which indicated severely impaired cognition. The resident had diagnoses of renal insufficiency, renal failure, ESRD (end stage renal disease), heart failure (heart muscle can't pump enough blood to meet the body's needs for blood and oxygen causes shortness of breath and fatigue), non-Alzheimer's dementia, anxiety, depression, bilateral hearing loss, and dysphagia (difficulty swallowing foods or liquids). The resident had a loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a prescribed weight loss program. The Weight Log revealed, in pertinent part: 1. The resident weighed 195.4 pounds (lbs.) on 11/1/23. 2. The resident weighed 190 lbs. on 11/4/23. 3. The resident weighed 171.4 lbs. on 11/20/23. 4. The resident weighed 164.2 lbs. on 2/5/24. 5. The resident weighed 158.8 on 3/11/24. The Nutrition Risk assessment dated [DATE] signed by Staff N, Registered Dietician (RD) revealed, in pertinent part, that the resident had a weight loss of > (greater than) 5% in 1 months; >7.5% in 3 months; >10% in 6 months. Progress Notes revealed, in pertinent part: 1. Post Fall Evaluation on 2/17/24 at 5:14 PM, recent weight loss: no. 2. The next Progress Note related to the resident's weight loss occurred 3/8/24 at 3:44 PM, noted to be have a weight loss of 10LB in 60 days, physician notified per fax (facsimile). The Clinical Record lacked any other documentation of physician notification of the resident's weight loss. In an interview on 3/13/24 at 10:49 AM, when asked if the resident had a significant weight loss that should have been addressed sooner than 3/8/24, the Regional Nurse Consultant (RNC) agreed. The Nutrition and Weight Management Standard Policy dated August 2021 directed, in pertinent part: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Suggested parameters for evaluating significance of unplanned and undesired weight loss are: 6 month interval greater than 10% was a severe loss. 2. If a resident triggers a weight loss, the Director of Nursing (DON) will run a Weight Variance Report to see all triggered weights. Process will then be determined as to: a. RD consultation. b. MD (medical doctor) notification. c. Family notification. d. New orders. e. Medications review. f. Weights more frequently obtained. g. Care plan updates. h. MDS updates. 49056 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #11 documented diagnoses of seizure disorder, traumatic brain injury, bipolar disorder and psychotic disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Review of Resident #11' s clinical record reviewed the following information: On 12/18/2023, the resident weighed 167.2 pounds (lbs). On 01/15/2024, the resident weighed 156.2 pounds which is a -6.58% Loss. Review of Resident #11' s weights showed the last weight taken on 1/15/24 was 156.2 lbs. There were no weights taken after this date. Review of Resident #11' s MDS dated [DATE] revealed on Section K 0300, weight loss, was coded 2 for yes, not physician prescribed weight loss regimen. Review of Resident #11' s care plan with a target date of 5/29/24 lacked information regarding the significant weight loss or interventions in place to prevent further weight loss. Review of Resident #11' s Dietary Progress Note on 2/22/24 revealed weight is down 6.6% in 30 days which is a significant weight loss. Review of Resident #11' s clinical chart lacked documentation of the physician being notified regarding significant weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/13/24 at 3:00 PM, with the Director of Nursing (DON) revealed the physician should have been notified of the significant weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 49056 Based on observations and staff interview, the facility failed to post accurate nurse staffing data in a prominent location and visible to residents and visitors. The facility reported a census of 29 residents. Findings include: Observation on 3/13/24 at 11:00 AM, revealed a daily staffing sheet hanging behind the nurses station dated 3/13/24 that did not include hours worked. Observation on 3/14/24 at 10:31 AM , revealed a daily staffing sheet hanging behind the nurses station dated 3/14/24 that did not include hours worked. The facility does not have a policy regarding daily staff posting. Interview on 3/14/24 at 2:00 PM., with the Director of Nursing revealed the night shift nurse is to be doing the sheets and expects this to be completed daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, resident, and staff interview, the facility failed to provide social services staff for 3 of 3 residents reviewed (Residents #20, #25, and #26). The facility reported a census of 29 residents. Findings include: 1. In an interview on 3/11/24 at 11:26 AM, Resident #20 reported she didn't know anything about care conferences, had never been invited to one. The Care Conference Note on 10/27/23 at 3:23 PM written by Staff H, Social Services Designee, lacked information that the resident or resident representative was invited to the care conference. In an interview on 3/13/24 at 10:49 AM, Staff H, Social Service Designee, reported that she started in this role 2 months ago, prior to this, the previous Director of Nursing (DON) managed care conferences. 2. In an interview at 3/13/24 at 9:50 AM, the DON reported that Resident #25 did not have a bed hold obtained at the time he was transferred to the hospital because he was not cognitive enough to feasibly do this at the time. Clinical Record review for Resident #25 revealed: 1. No assessment from Social Services or a Social Services Designee. 2. Clinical Profile did not contain any resident contacts. 3. The MDS from the resident's admission on 9/7/24 revealed that he had a Brief Interview on Mental Status (BIMS) score of 9 which indicated moderately impaired cognition. 4. The MDS dated [DATE] revealed the resident had diagnoses of seizure disorder or epilepsy, traumatic brain injury, anxiety, and depression. 5. The History and Physical signed by a physician on 8/16/23 revealed the resident had been living in a home less shelter with his fiancee with home health services in North Dakota. In an interview on 3/19/24 at 3:30 PM, the resident reported that he has had a case manager from his insurance company visit him in the facility 2 times since his admission, has not had social services provide an assessment since he has been admitted , that he chose to move to this facility when he was hospitalized in North Dakota, that he would like his 2 sisters and one of his sons to be listed as contacts in his medical record so that they can be involved in his care and that he talks with his family regularly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 3/19/24 at 3:45 PM, the DON reported that the resident did not want any other people listed as contacts in his medical record or anyone involved in his care. 3. The PASSR dated 2/23/24 for Resident #26 revealed that determination was to refer for Level II onsite. In an interview on 3/13/24 at 10:49 AM, the Administrator reported that Staff Q, Regional Business Development Director, works remotely and does tasks related to Preadmission Screening and Resident Review (PASSR). The Administrator talked with staff at Maximum (company that manages PASSR) and did not know when the Level 2 review was scheduled to take place. In an interview on 3/13/24 at 6:15 PM, Staff H reported that she has no qualifications to support the Administrator adding Social Service Designee to her role as Activity Director, but that she was told she would be taking a class sometime. Staff H reported that she is transitioning into Social Service Designee, currently she is tasked with managing care conferences and completing section F for resident's MDS assessments. Staff H reported that should she have any questions about Social Service Designee responsibilities, she brings them to the Administrator. When asked if the kitchen continue to rely on her as she was the Dietary Manager prior accepting the Activity Manager position, Staff H agreed and reported that she has a lot of different roles at the facility. The document Social Services Director, undated, revealed job duties and responsibilities as follows, in pertinent part: 1. Assist in PASSR. 2. Assist resident in the decision making process concerning their own health care, and whether or not they would like anyone else to be involved in those decision. 3. Coordinate the scheduling of care plan meetings and assessment ot be presented and discussed at each meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to ensure licensed nurses obtained timely laboratory services as ordered by a physician for 1 of 12 residents reviewed (Resident #27). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #27 revealed a Brief Interview of Mental Status (BIMS) score of 6 which indicated severely impaired cognition. The resident had diagnoses of renal insufficiency, renal failure, ESRD (end stage renal disease), heart failure (heart muscle can't pump enough blood to meet the body's needs for blood and oxygen causes shortness of breath and fatigue), non-Alzheimer's dementia, anxiety, depression, bilateral hearing loss, and dysphagia (difficulty swallowing foods or liquids). The Health Status Note on 3/8/24 at 5:41 PM revealed faxed order received from physician regarding the weight loss, obtain a CBC (complete blood count) et (and) CMP (comprehensive metabolic panel), message left for DPOA (durable power of attorney). The Health Status Note on 3/12/24 at 10:06 AM revealed physician here for resident rounds, see resident, new order for Nutritional supplement TID with meals, due to recent weight loss. Noted and placed in resident files. The Clinical Record lacked documentation that the laboratory order on 3/8/24 received via fax was in the resident's Electronic Health Record (EHR) or that the laboratory order had been performed. In an interview on 3/13/24 at 10:49 AM, when asked about the location of the fax with the laboratory order, whether or not the laboratory order had been performed, and it was performed, where the results were located, the Administrator reported that when she started in February 2023, no records were scanned into the resident's EHR and that each department was responsible for scanning records. The Director of Nursing (DON) reported that she started 3/4/24 and did not know before starting the state the nursing department's medical records were in before she started, that it was obvious to her that the previous DON did not keep up on scanning records in and they were located in boxes and binders throughout her office. The Health Status Note on 3/13/24 at 2:19 PM revealed blood drawn this a.m for a CMP et CBCD (complete blood count with differential) from the left antecubital area without difficulties, tolerated well. Specimen taken to local hospital, results received et faxed to physician. In an interview on 3/13/24 at 3:40 PM, the Regional Nurse Consultant (RNC) reported that the process for orders is that after the order is received, the first check is by a nurse, then the order is placed in a box labeled orders where a second nurse verifies the order. The order is then placed in a filing cabinet at the nurse's desk with a file for each resident waiting to be scanned into their EHR. Whichever staff is filing or scanning into the resident's EHR takes the file from the nurse's desk into a box in DON's office. The RNC reported that she did not know why this resident's lab order didn't get entered into her EHR and that the order should have been performed sooner than 3/13/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Services Policy dated October 2023 directed, in pertinent part: 1. All physician's orders for each resident shall be entered into the EHR immediately upon receipt. 2. Physician orders include laboratory. 3. It is the standard of this facility that all physician's orders will be appropriately transcribed and noted by a licensed nurse. 4. Physician's orders are to be noted by a licensed nurse at the time that the orders are written/approved by the physician. 5. The nurse who notes the order will transcribe the order onto the appropriate medication administration record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 1304 South Market, Lake Park, IA 51347	

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 26527 Based on personnel file review, and staff interview, the facility failed to have a Certified Dietary Manager (CDM) on staff. The facility reported a census of 29 residents. Findings include: On 3/11/24 at 2:45 p.m. the Administrator stated they could not get the Dietary Manager (DM) into a food service manager course until July. The previous DM was in the class and quit working at the facility. A course registration form showed the facility signed authorization for the DM's enrollment on 2/26/24. Information received from the college indicated the dietary manager course started in July. On 3/12/24 at 4:16 p.m. the Dietician stated DM's were to have a certification as CDM or certified food service manager (CFSM) on hire, but that was hard to find.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 26527 Based on observation and staff interview the facility failed to provide sufficient support personnel to safely and effectively carry out the functions of the dietary services including sanitation, following proper sanitation and food handling practices, and food temperatures. The facility reported a census of 29 residents. Findings include: During initial tour of the kitchen on 3/11/24 at 8:53 a.m. observed the following: a. The hand washing sink had so many things sitting around it, it was difficult to get to it. b. It was dirty around the (handwashing sink) faucet. c. There were open packages of shredded cheese in the fridge across from the hand washing sink, not dated. d. The base of the fridge was covered in a slimy gritty substance. e. The can opener had food crusted on the part that punctures the can. f. The floor below had red and brown soiling. g. Underneath the counter had a pool of brown liquid. h. The cart the flour bin sat on had flour on it. i. The oven hood appeared quite grimy. Staff H Activity Director, former Dietary Manager (DM) stated they came to clean the hood 1 time/year. Doesn't recall ever cleaning the hood filters. She looked where they had the cleaning schedules and stated they were not there. On 3/11/24 at 11:03 a.m. the Dietary Manager (DM) pureed peas then placed the pureed peas in the steam table without temping. The DM was asked to temp the food, and it temped at 118 degrees. Staff H, previous DM said it would need to be reheated. The DM ground 6 servings of chicken, measured, and determined scoop size. The DM went to put it in the steam table. She was asked to temp the ground food. It temped at 117 degrees. The DM reheated the ground meat in the microwave. The DM wore gloves and touched multiple surfaces then handled the bread (with same gloves on). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:02 p.m. the DM ready to serve with Staff H and Staff F Cook assisting. All 3 wore gloves and touched multiple surfaces. Staff H picked up the bread wearing the same gloves and the DM touched the chicken wearing the same gloves. Residents on a regular diet asked for meat to be cut up. The DM touched the chicken intermittently wearing the same gloves she started with, and Staff H pickup up the buttered bread with same the gloves on. On 3/12/24 at 8:17 a.m. Staff E, Laundry going in and out of the kitchen to assist with breakfast. Her bangs hung out of her hair net in the front and longer hair hung out in the back. Staff E touched her face and then obtained and gave a glass of juice to a resident. On 3/12/24 at 8:38 a.m. dietary staff brought out 4 room trays on a cart. There were no drinks on the trays. The dietary aide and Staff E were getting the drinks. At 8:48 a.m. the carts had their drinks. The Certified Nursing Assistant (CNA) said they were waiting for another CNA so she could take the trays to the resident's rooms. The cook was asked to temp the food. The 1st tray eggs temped at 103.2 degrees. The cook said they would reheat all of them. The undated facility policy, Personnel Management, documented sufficient staff would be employed, oriented, trained and their working hours scheduled to provide for the nutritional needs of the residents and to maintain the Dietary Department.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 26527 Based on observation, review of facility menus, and staff interview, the facility failed to follow the menu as written for 3 meals observed. The facility reported a census of 29 residents. Findings include: 1) The lunch menu for 3/11/24 included: Seasoned peas 4 ounces., Wheat bread and margarine. The therapeutic lunch menu for 3/11/24 revealed the L3/Advanced (mechanical soft) diet included: 1/2 cup (4 ounces) of seasoned peas pureed, 1 slice of wheat bread and margarine. The therapeutic lunch menu for 3/11/24 revealed the L1/Puree diet included: 1/2 cup pureed peas, 1 slice of pureed bread and margarine. On 3/11/24 at 11:03 a.m. Staff G Dietary Manager prepared peas for 2 residents on a pureed diet. She placed 2, 3 ounce scoops of peas in the robot coupe and pureed with some beef broth. Staff G measured and determined scoop size. Staff G went to serve mechanical soft diets peas when the menu called for pureed peas. Neither Staff H previous DM or Staff G had looked at the therapeutic menu (spreadsheet). Staff H went to call the dietician. When she returned she said the dietician said to puree the peas or give an alternate soft vegetable. She said they didn't have the alternate available so Staff G pureed 6, 3 ounce servings of peas, for mechanical soft diets. She then ground 6 servings of chicken measured and determined scoop size. Staff G pureed 2 pieces of chicken and 1 slice white bread of bread for the 2 pureed diets (the menu called for a slice of bread for each resident), measured and determined scoop size. Staff G served all other residents 3 ounces of peas. Residents received white bread. On 3/11/24 at 1:10 p.m. Staff H stated the resident's diet orders were on the white board. She had not checked the therapeutic menus for portion sizes, or the mechanical soft diet to see they could not have regular peas. They did not have diet cards, just the white board. 2) The lunch menu for 3/12/24 included a wheat roll. On 3/12/24 at 11:49 a.m. serving residents lunch. Residents received white bread. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/24 at 4:16 p.m. the Dietician said they needed to follow the menu as written. If they needed to make a substitution they needed to let her know and put it in the substitution book. She said they have to check the therapeutic menu for portion sizes, and what to serve the mechanical and puree diets. 3) The dinner menu for 3/12/24 included wheat bread. On 3/12/24 at 5:38 p.m. Staff F, Cook, had 2 dietary aides. Serving white bread. Staff stated that was all they had. Looked at the substitution notebook and there had been no subs documented in March. Staff H talked Staff F through the puree and ground process. The undated facility policy, Menus documented menus must be followed as written. The undated facility policy, Therapeutic Diets documented therapeutic diets were prepared and served as ordered by the attending physician. Therapeutic diets were planned, prepared and served with supervision or consultation from a qualified dietician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0805

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 26527

Based on observation, record review, menu review, and staff interview the facility failed to assure residents received food in a form to meet the needs of 2 of 6 residents reviewed (Resident #9 and #7) and prepared to serve the inappropriate texture of food to 6 of 6 residents (Resident #6, #7, #9, #10, #11, and #17) on a mechanical soft diet, and 2 of 2 residents on a pureed diet (Resident #1 and #20). The facility reported a census of 29 residents. Resident #9 upgraded from a pureed diet to a mechanical soft diet on 3/4/24. On 3/10/24 Resident #9 received meat cut up instead of ground per the menu, and choked. The facility continued to serve residents on mechanically altered diets food in a form not on their diet.

The facility's non-compliance resulted in an immediate jeopardy situation. The facility was notified 3/13/24 at 3:46 p.m. of the immediate jeopardy beginning 3/10/24.

Information provided at 3-14-24 meeting by Dietician was:

Diet orders-what orders are used in this facility and nursing to provide diet order to dietary in written form.

Menu cards-how to read them to properly serve residents their diet and nursing/server to provide as double check that correct order is being followed.

Diet spreadsheets- how to read menu spreadsheets for accuracy in serving the diet order.

Menu substitutions how to appropriately make substitutions for like nutrient value.

How to serve food and beverages in sanitary manner- no touching top rim of glasses, no thumbs on plate, barrier between hands and ready to eat foods, wash hands between tasks and change gloves between tasks.

With Kitchen staff:

Reviewed mech soft, and pureed process.

How to read spreadsheets and proper potion sizes, scoops to use.

Taking temps of food and equipment and record daily and at each meal.

Kitchen sanitation and labeling and dating open foods

Additional Education: Video Training including Food Prep 101, Nutrition 101, Sanitation 101, Dining 101.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 1304 South Market Lake Park, IA 51347	

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Tray cards use written stickers with name of diet type printed on them which are color coded so staff can easily identify the correct diet consistency for the resident. The new staff are educated and learning how to read the diet card for serving the correct diet order to each resident, Admin will orientate each dietary staff 1:1 on tray card process. The facility implemented their plan of correction and abated the immediacy on 3/14/24 at 6:11 p.m and the scope was lowered from a K to a E. Finding's include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #9 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had diagnoses including dysphagia (difficulty swallowing) oropharyngeal phase and cognitive communication deficit. The Care Plan identified the resident had a choking episode with a goal target date of 3/11/24. The interventions included encouraging all residents to eat all meals in the dining room, a new order for mechanical soft diet with ground meats, resident to be monitored closely with meals, and staff encouraging the resident to chew food well and take drinks frequently. The Care Plan identified the resident had altered nutritional status. The interventions included diet as ordered: regular diet, mechanical soft with ground meats texture, thin consistency (liquids). The Care Plan identified the resident had oral/dental health problems related to being edentulous (no teeth). The interventions included diet as ordered and consult with the dietitian and change if chewing/swallowing problems were noted. The Clinical Physician's Orders revealed the resident had the following diet orders: a. Regular diet, pureed texture, thin consistency related to dysphagia, oropharyngeal phase, with a start date of 7/13/22, and discontinuation date of 11/3/23. b. Regular diet, pureed texture, nectar consistency, with a start date of 10/2/23 and discontinuation date of 3/4/24. c. Regular diet, mechanical soft texture with a start date of 3/4/24. The Progress Notes dated 3/1/24 at 6:04 p.m. documented receipt of the okay for a Speech Therapy (ST) evaluation. Notified the resident, and gave a copy to therapy. A Therapy to Facility Communication dated 3/2/24 documented Speech Therapy Recommendation for Resident #9: Okay to upgrade diet to mechanical soft, thin liquids. Continue dysphagia treatment to train on safe swallow techniques: 1. Small bites/sips, 2. Alternate bites of food with sips of liquid, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. No raw vegetables, 4. No raw fruits, 5. Extra sauces/gravy. The Progress Notes dated 3/4/24 at 10:23 a.m. documented receipt of a fax regarding the resident's diet. Okay to upgrade diet to mechanical soft, thin liquids per speech therapy recommendations, copy given to dietary, noted and placed in resident files. The lunch menu for 3/10/24 included 3 ounces of cranberry glazed ham. The mechanical soft/L3/Advanced diet included ground cranberry glazed ham. The Progress Notes dated 3/10/24 at 1:10 p.m. documented the resident had a choking episode on ham at lunch. After patting on the resident's back and the resident coughing to clear airway, food was dislodged. The resident recently upgraded diet from pureed to mechanical soft. Sent a fax to the provider updating him of the incident and requesting an order to grind meats. The resident agreed. On 3/13/24 at 2:04 p.m. Staff I Licensed Practical Nurse (LPN) stated on 3/10/24 Resident #9 choked on ham. It was cut up into cubes. Staff I stated she didn't have to do the Heimlich, rather patted her on the back and she coughed and expelled the chunk. She asked why the resident didn't get ground meat and the cook said she was mechanical soft, and that mechanical soft and ground meat were 2 different things. Staff I said she sent for an order for ground meat. 2) According to the MDS assessment dated [DATE] Resident #7 scored 10 on the BIMS indicating moderate cognitive impairment. The resident had diagnoses including dysphagia oropharyngeal phase. The Care Plan identified the resident at risk for malnutrition. The interventions included diet as ordered. The Clinical Physician's Orders documented the resident had orders for regular diet, mechanical soft texture, with a start date of 7/21/23 and a discontinued date of 3/14/24. On 3/11/24 during the lunch service, staff made a grilled cheese sandwich (per resident request) and served Resident #7. According to the supper menu for 3/13/24 (to determine if grilled cheese acceptable) residents on mechanical soft/L3 advanced diet would received a cheese sandwich instead of a grilled cheese sandwich. The clinical record lacked documentation the resident received education on her diet. 3) According to the MDS assessment dated [DATE] Resident #6 scored 15 on the BIMS indicating no cognitive impairment. The resident had diagnoses including non-Alzheimer's dementia. The resident had a mechanically altered diet. The Medical Diagnosis page showed Resident #6 had a diagnosis of dysphagia. The Care Plan identified Resident #6 was at risk for alterations in nutritional status due to obesity. The interventions included diet as ordered: Controlled carbohydrates and mechanical soft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4) According to the MDS assessment dated [DATE] Resident #10 scored 10 on the BIMS indicating moderate cognitive impairment. The resident had a mechanically altered diet. The Care Plan identified the resident at potential risk for altered nutrition related to the need for consistency altered diet. The interventions included serving diet as ordered: regular, mechanical soft, ground meat. 5) According to the MDS assessment dated [DATE] Resident #11 scored 4 on the BIMS indicating severe cognitive impairment. The resident had diagnoses including dysphagia oropharyngeal phase. The resident had a mechanically altered diet. The Care Plan identified the resident was at risk for alterations in nutritional status relating to her wanting to sleep in when breakfast was being served. The interventions included diet as ordered, mechanical soft texture. 6) According to the MDS assessment dated [DATE] Resident #17 scored 11 on the BIMS indicating moderate cognitive impairment. The resident had diagnoses including dysphagia and aphasia (language disorder). The Care Plan with a goal target date of 5/29/24 identified Resident #17 at risk for alterations in nutritional status. The interventions included diet as ordered: CCH Controlled Carbohydrates, Mechanical Soft 7) According to the MDS assessment dated [DATE] Resident #1 had long and short term memory problems and modified independence for cognitive skills for daily decision making. The resident had diagnoses including non-Alzheimer's dementia. According to the Medical Diagnosis page, Resident #1 had diagnoses of oral phase and 0ropharyngeal phase dysphagia. The Care Plan with a goal target date of 3/25/24 identified Resident #1 with the potential for alteration in nutrition related to the need for a therapeutic and mechanically altered diet with thickened liquids. The interventions included serving diet as ordered: Consistent carb, pureed, nectar thick liquids. 8) According to the MDS assessment dated [DATE] Resident #20 scored 12 on the BIMS indicating moderate cognitive impairment. The resident had diagnoses including a stroke and dysphagia. The resident had a mechanically altered diet. The Care Plan with a goal target date of 5/20/24 identified Resident #20 at risk for malnutrition. The interventions included diet as ordered: CCH, pureed, nectar consistency liquids The lunch menu for 3/11/24 included: Seasoned peas. The mechanical soft/L3/Advanced diet and puree diets included: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Green peas pureed. On 3/11/24 at 11:03 a.m. the Dietary Manager (DM) prepared to puree peas for 2 residents on a pureed diet. She placed 2, 3 ounce scoop of peas in the robot coupe and pureed with some beef broth. She was going to serve mechanical soft diets regular peas, and the menu called for pureed peas. When questioned about serving the peas unaltered to residents on a mechanical soft diet they did not know the answer. Neither the DM or Staff H Activities, previous DM had looked at the therapeutic menu. Staff H went to call the dietician. When she returned she said the dietician said to puree the peas or give an alternate soft vegetable. She said they didn't have the alternate available so the DM pureed 6, 3 ounce servings of peas, for mechanical soft diets. At 12:02 p.m. the DM plated a mechanical soft diet. Staff H went to walk out of the kitchen with regular peas on the plate. Again questioned if they could have regular and Staff H said it should be the pureed peas. The DM plated the 2 purees and put regular peas on the plate. Staff stopped from serving regular peas to residents on a pureed diet. On 3/11/24 at 1:10 p.m. Staff H stated the resident's diet orders were on the white board. She had not checked the therapeutic menus for portion sizes, or the mechanical soft diet to see they could not have regular peas. They did not have diet cards, just the white board. On 3/12/24 at 4:16 p.m. the Dietician stated they had to check the therapeutic menu for portion sizes, and what to serve the mechanical and puree diets. On 3/14/24 at 11 a.m. the Dietician stated mechanical soft was ground meat unless the Speech Therapist (ST) specified something else. She said they talked about different things on the menu including grilled cheese and she said they would get a cheese sandwich, unless it was care planned differently. She said there were some vegetables and fruits that had a tougher skin and would not be on a mechanical soft diet unless altered. She said a mechanical soft diet would equate to the L3/Advanced diet on the therapeutic spread sheets On 3/14/24 at 5:25 p.m. Staff F Cook/Dietary Aide (DA) admitted he had not understood the mechanical soft diets were supposed to have ground meat, or that some of the fruits and vegetables were different textures. The undated facility policy, Mechanical Soft Diet, documented the mechanical soft diet was modified in consistency to reduce the amount of chewing required to consume food. The diet was intended for persons who may have difficulty chewing solid foods. It was appropriate for individuals with little or no teeth, poor fitting dentures, oral lesions or irritated esophageal lining. The undated facility policy, Mechanical Soft Food Preparation, documented the procedure: 1. Portion out the number of servings needed. 2. Place food in the processor to be mechanically altered to the proper consistency. 3. All meats with the exception of unbreaded baked fish should be mechanically altered using the food processor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. When preparing meats, serve with gravy or sauce to add moisture. 5. Follow dietary restrictions and manufacturer's directions when using additives in foods to assure proper consistency. 6. Mechanical soft foods must be ground to the proper consistency per the resident's needs. The undated facility policy, Therapeutic Diets documented therapeutic diets were prepared and served as ordered by the attending physician. Therapeutic diets were planned, prepared and served with supervision or consultation from a qualified dietician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26527 Based on observation and staff interview, the facility failed store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility reported a census of 29 residents. Findings include: During initial tour of the kitchen on 3/11/24 at 8:53 a.m. observed the following: a. The hand washing sink had so many things sitting around it, it was difficult to get to it. b. It was dirty around the (handwashing sink) faucet. c. There were open packages of shredded cheese in the fridge across from the hand washing sink, not dated. d. The base of the fridge was covered in a slimy gritty substance. e. The can opener had food crusted on the part that punctures the can. f. The floor below had red and brown soiling. g. Underneath the counter had a pool of brown liquid. h. The cart the flour bin sat on had flour on it. i. The oven hood appeared quite grimy. Staff H Activity Director, former Dietary Manager (DM) stated they came to clean the hood 1 time/year. Doesn't recall ever cleaning the hood filters. She looked where they had the cleaning schedules and stated they were not there. On 3/11/24 at 11:03 a.m. the Dietary Manager (DM) prepared to puree peas for 2 residents on a pureed diet. She placed 2, 3 ounce scoop of peas in the robot coupe and pureed with some beef broth. She measured and determined scoop size. She placed the pureed peas in the steam table without temping. The DM was asked to temp the food, and it temped at 118 degrees. Staff H, previous DM said it would need to be reheated. The DM reheated the pureed peas in the microwave. The DM pureed 6, 3 ounce servings of peas, for mechanical soft diets. The DM then ground 6 servings of chicken, measured, and determined scoop size. The DM went to put them in the steam table. She was asked to temp the ground food. It temped at 117 degrees. The DM reheated the ground meat in the microwave. The DM wore gloves and touched multiple surfaces then handled the bread (with same gloves on). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:02 p.m. the DM ready to serve with Staff H and Staff F Cook assisting. All 3 wore gloves and touched multiple surfaces. Staff H picked up the bread wearing the same gloves and the DM touched the chicken wearing the same gloves. Residents on a regular diet asked for meat to be cut up. The DM touched the chicken intermittently wearing the same gloves she started with, and Staff H picked up up the buttered bread with same the gloves on. On 3/11/24 at 1:10 p.m. Staff H stated she had tongs for serving the bread and then didn't use them. On 03/12/24 at 8:17 a.m. Staff E Laundry went in and out of the kitchen to assist with breakfast. She had hair hanging out of hair net in the front and back. Staff E touched her face and then obtained and gave a glass of juice to the resident. On 3/12/24 at 8:38 a.m. the kitchen sent out 4 room trays on a cart. There were no drinks on the trays. The dietary aide and the laundry aide were getting the drinks. At 8:48 a.m. the carts had their drinks. The Certified Nursing Assistant (CNA) said they were waiting for another CNA so she could take the trays. The cook was asked to temp the food. The 1st tray eggs temped at 103.2 degrees. The Dietary Manager said they would reheat all of them. On 3/14/24 at 12:22 PM milk temps done since residents were in the dining for lunch to start at 11:30 a.m. but lunch was not served until 2 purees at noon and the rest at 12:15 p.m. The 3 milks temped at 44.7, 51.5, and 58.3 degrees. On 3/14/24 at 1:17 p.m. during the meal service, the DM pureed 1 serving of pureed meat and 1 slice of bread. She covered and placed it in the steam table. The DM was asked to temp it, and it was 118 degrees. She heated in the microwave. During the meal service, a window was open and blowing into the kitchen. The window interior and the lower rim of the window were dirty. The dumpsters outside that could be seen from the same window had garbage sticking up with no cover. The CNA Staff P working in the kitchen confirmed the same. The FDA Food Code 2017 included: a. Reheating for Hot Holding, food that was cooked, cooled, and reheated for hot holding should be reheated so that all parts of the food reached a temperature of at least 165 degrees. b. Food employees should wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covered body hair, that were designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens, and unwrapped single service and single use articles. c. If used, single use gloves should be used for only one task such as working with ready to eat food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occurred in the operation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 1304 South Market Lake Park, IA 51347	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Time/temperature controls for food safety documented cold food should be maintained at 41 degrees or less. The facility undated Sanitation/Infection Control policy documented the Dietary Manager was responsible for supervising all sanitation and housekeeping procedures within the the dietary department. The DM and consultant dietician developed a cleaning schedule. The DM was responsible in proper sanitation procedures for storing, preparing, and serving food. A clean department was essential for good sanitation. Light daily cleaning was required for the can opener, hand washing sink, and refrigerator. Once weekly cleaning of refrigerators and freezers. Procedure for Cleaning refrigerator: Once a week, wash thoroughly inside and outside with a detergent solution. Remove all food from the shelves. Check with the supervisor and throw out all that was not usable. Rinse with water to which a sanitizer had been added and wipe with a clean dry cloth. Procedure for Cleaning Hood Filter Over Stove: Remove screen or vent from over stove. Run screen or vent through the dishwasher. Remove and let dry. Wipe off hood completely with a degreaser. Replace screens over stove. Hoods and ducts were cleaned at least monthly to prevent grease buildup, which created a fire hazard as well a sanitation problem. Ducts were professionally cleaned every six months. 44475

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 26527 44475 Based on observation, Food Safety Code, and staff interview, the facility failed to cover trash containers in the kitchen or cover trash dumpster outside the facility. The facility reported a census of 29 residents. Findings include: Observation on 3/13/24 at 5:30 PM revealed an uncovered trash can under a table in the kitchen, next to bulk flour storage. Observation on 3/14/24 at 8:00 AM revealed an uncovered trash can under a table in the kitchen, next to bulk flour storage. Observation on 3/14/24 at 11:15 AM revealed an uncovered trash can under a table in the kitchen, next to bulk flour storage. Observation on 3/14/24 at 1:17 PM of the dumpster outside that could be seen from the window in the kitchen, the dumpster had garbage sticking up over the top with no cover. Staff P, Certified Nurse Assistant (CNA) working in the kitchen as a dietary aide confirmed the dumpster was not covered. The Food Safety Code 2022 directed, in pertinent part: 1. Refuse shall be stored in receptables or waste handling units so that they are inaccessible to insects and rodents. 2. Receptacles and waste handling units for refuse shall be kept covered: a. inside food establishment if the receptacles and units 1. Contain food residue and are not in continuous use; or 2. after they are filled; and b. with tight-fitting lids if kept outside the food establishment. In an interview on 3/19/24 at 3:45 PM, when asked if the trash inside the kitchen and the dumpster outside the facility should be covered, the Administrator agreed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44475 Based on clinical record, facility policy, and staff interview, the facility failed to maintain medical record that are complete, accurate, readily accessible, and systematically organized. The facility reported a census of 29 residents. Findings include: In an interview during entrance conference on 3/11/24 at 9:00 AM, the Director of Nursing (DON) reported that all resident records were located on the facility's Electronic Health Records (EHR) system, there were no hard charts for residents. When asked if there was a system in place for documents waiting to be scanned into the EHR, the DON reported that she was not sure as she just starting working at this facility on 3/4/24. Observation on 3/11/24 at 9:00 AM of the Director of Nurse's office which contained boxes labeled scanned, some of which had file folders, binders were in the office containing resident information. In an interview on 3/13/24 at 1:47 PM, the Administrator provided a PASSR Level II for Resident #26. The PASSR Level I dated 2/19/24 directed that a PASSR Level II be performed. When asked if it should take weeks for clinical documentation (PASSR Level II) to be placed in the resident's clinical record, the Administrator replied, no. In an interview on 3/13/24 at 12:25 PM, the DON reported that Resident #3's superior abdominal wound started 1/4/24. When Staff S's weekly documentation was requested from the DON, 4 weeks were provided dated: 2/8/24, 2/28/24, 3/6/24, and 3/13/24. In an interview on 3/13/24 at 2:49 PM, Staff S, Wound Ostomy Continence Nurse (WOCN) reported that there have been 2 occasions in which she has reviewed Resident #3's EHR and noted that the wound care orders are not current, out dated by 2-3 weeks. Staff S reported that she would expect a complete medical record accessible the nursing department staff with wound assessments and wound care orders. The process she has with her wound care visits with residents is that she uses paper to document, leaves a copy with the facility to upload into the EHR. In an interview on 3/18/24 at 1:35 PM, the Regional Nurse Consultant (RNC) reported that the Progress Note for the resident's discharge in the electronic health record (EHR) did satisfy criteria for a discharge summary. The RNC pointed to the stack of boxes and reported that she was unable to find additional information in the boxes of medical records in the DON's office. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165445	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 3/13/24 at 10:49 AM, the Administrator reported that the facility does not have dedicated staff to perform medical records management, primarily scanning paper records in resident's electronic health record (EHR) as the facility does not use paper charts for resident's medical records. Starting 3/4/24, Staff R, Registered Nurse (RN) performs this as needed only. When the current Administrator started in February 2023, she found that no medical records were scanned into the EHR. From February 2023 until 2/4/24, each department was responsible for scanning their own records. The Health Information Management Manual revised 2021 directed, in pertinent part: 1. All records including active, overflow, and discharge records, will be readily accessible, assembled, and maintained in uniform chart order. The records are filed in an easily retrievable manner and maintained in folders or chart holders sufficient in size for the volume of the record. 2. Store records in a secure and protected manner. 3. Facility leadership will review and analyze the health information management process at least quarterly. Leadership review is done at the direction of and through the Administrator. 4. Data reviewed includes information gathered through quantitative and qualitative audits. The Health Information Manager or designee uses these audits to assure the content, completion, timeliness, and accuracy of medical record documentation. a. Quantitative Audits - Review documents for completeness, authenticated signatures, and timeliness. b. Qualitative Audits - Review the quality of documentation evaluating adherence to clinical practice guidelines, consistency in charting, and adherence to regulation, standards, and interpretations; a clinician or health information consultant completes the qualitative audit. 5. Audit findings that cannot be corrected will be gathered for Quality Assurance Process Improvement functions including training/retraining and evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 1304 South Market Lake Park, IA 51347	

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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 26527 Based on record review and staff interview, the facility failed to include the selection of a venue convenient to both parties in the arbitration agreements provided for 3 of 3 residents reviewed (Resident #20, #21, and #22). The facility reported a census of 29 residents. Findings include: 1. A review of the Arbitration Agreement revealed Resident #20 electronically signed an agreement that did not specify selection of a venue convenient to both parties, on 7/28/23. 2. A review of Arbitration Agreement revealed Resident #21's guardian electronically signed an agreement that did not specify selection of a venue convenient to both parties, on 3/23/22. 3. A review of the Arbitration Agreement revealed Resident #22 electronically signed an agreement that did not specify selection of a venue convenient to both parties, on 2/8/23. An updated version of the facility Arbitration Agreement included the agreement provided for the selection of a venue that was convenient to both parties. On 3/13/24 at 10:28 a.m. the Administrator stated they added the piece about a venue convenient to both parties in October. They had sister facilities go through the survey process and found they had not met this requirement, so they updated their agreements at that time. They did not update the agreements previously entered into by the residents/responsible parties.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165445	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 44475 Based on facility policy and staff interview, the facility failed to implement a comprehensive Quality Assurance and Performance Improvement (QAPI) program with corporate governance and leadership oversight. The facility reported a census of 29 residents. Findings include: In an interview on 3/21/24 at 1:42 PM, the Administrator reported that this administrator position was the first one since received her administrator license, that she started this job February 2023 and received QAPI orientation February 2024. The Administrator reported that all facilities policies are developed by the corporation and no policies are developed at the facility. During the current survey, the Administrator has contacted the corporation for assistance, including ad hoc QAPI involvement. When asked how the corporation assists with transitions in the leadership of the facility, the Administrator reported she did not know, that she has supported leadership transitions since she has been at the facility. When the last recertification survey's deficiencies and the pattern of repeated deficiencies were reviewed to determine if they were part of the facility's QAPI program, the Administrator reported they had not, that she was learning as she went and she planning on bringing the current survey's deficiencies to the QAPI program. The Quality Assurance Performance Improvement (QAPI) Management Policy dated January 2024 directed, in pertinent part: 1. The QAPI Program provides an opportunity for the facility to assess current practice and procedures in order to determine a plan for improvement in the quality of care. 2. Purpose: to develop, implement, and maintain an ongoing program designed to monitor and evaluate customer satisfaction and the quality of resident care, pursue methods to improve quality care and other facility services, and to resolve identified problems. 3. The governing body of this facility shall be ultimately responsible for the QAPI program. The Administrator represents the governing body of this facility. 4. Plans of improvement: a. Program developed by the QAPI committee that involve any number of actions intended to improve the quality of services delivered to the facility's residents. These actions may include data collection, changes in procedures, and modifications of certain facility practices. b. Describe issues of concern, outline an approach intended to alleviate the issue and set a specified goal. This completed plan of improvement will specify the benchmark and the measures by which outcomes can be judged. Plan of improvement will always have a time frame in which modifications are to be made, measures are to be collected and results are to be submitted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Should a problem or concern be widespread, serious, and/or interdisciplinary in nature, a resident grievance/concern/complaint report shall be developed by the individual or group of individuals who discovered the issue. The report shall be submitted to the QAPI program coordinator for review at the next monthly QAPI committee. 6. The minutes of all regular and specially called meetings of the QAPI committee will include at a minimum, 2567/POC (Plan of Correction) documents and human resources (staffing/retention/overtime/recruitment).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on observations, staff interview and infection control policy, the facility failed to provide proper hand hygiene with incontinence care, and wound care with 2 of 2 residents observed,(Resident #10 and #24). The facility reported a total census of 29 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #10 documented diagnoses of hypertension, coronary artery disease, and hyperlipidemia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Observation on 3/13/24 at 10:20 AM observed Staff J, Registered Nurse (RN) with wound care. Resident #10 observed laying in bed at this time, Staff J washed hands and applied gloves, with gloved hands Staff J proceeded to pick up the garbage can and bring it over to the bed, then opening the drawer to get the package of wipes out of the dresser, the left hand touched the hand rail on the bed. Then with the same soiled gloved hands, Staff J proceeded to reach into the zip lock bag with the treatment contents inside and pull them out and sit them on top of the bag. Staff J then pulled the wipes out of the package, proceeded to clean off the area to the left buttock with the soiled gloves and apply the first cream. Staff J removed and applied new gloves, then applied the second cream over the first cream, then took gloves off and washed hands. 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #24 documented diagnoses of Alzheimer ' s Disease, hypertension, and hyperlipidemia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Observation on 3/13/24 at 12:54 PM observed Staff K, certified nursing assistant (CNA), complete peri care with Resident #24. Observed Staff K enter the room and answer the call light. Staff K proceeded to stand Resident #24 off the toilet, then apply gloves without performing hand hygiene, with gloved hands proceeded to remove wipes out the package and perform peri care on Resident #24. Staff K then removed gloves, applied new gloves, then pulled pants up. Staff K then took gloves off and walked Resident #24 back to bed. Then Staff K performed hand hygiene. Review of the facility provided policy titled Infection Control Manual dated 06/2016 revealed the following information: The facility will follow the Center for Disease Control (CDC) Guidelines for handwashing. Hands must be washed after the following, including, but not limited to: Before and after eating, drinking, or smoking. Contact with blood/body fluids. Contact with contaminated items or surfaces. Contact with mucous membranes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Contact with a resident. Contact with wounds. Covering a cough or sneeze Initiating a clean procedure. Personal use of the toilet. Removal of gloves. Contact with hair (food service workers). Interview on 3/13/24 at 3:00 PM with the DON revealed the expectation for the staff is to perform hand hygiene prior to and after changing gloves with care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165445	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Lake Park	1304 South Market Lake Park, IA 51347

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to assure residents had access the most recent COVID-19 Vaccine for 5 of 5 residents reviewed (Resident #10, #19, #22, #27 and #29). The facility reported a census of 29 residents. Findings include: The United States (US) Department of Health and Human Services documented the COVID-19 milestones included: On September 11, 2023 the Food and Drug Administration (FDA) approved and authorized the emergency use of the updated Moderna and -BioNTech COVID-19 vaccines formulated to better protect against currently circulating variants. On October 3, 2023 the FDA authorized the updated Novavax COVID-19 Vaccine, Adjuvanted (ingredient used in some vaccines that helped create a stronger immune response) (2023-2024 Formula) for individuals ages 12 and older. On 2/28/24 the Center for Disease Control (CDC) Director endorsed the CDC Advisory Committee on Immunization Practices' (ACIP) recommendation for adults ages [AGE] years and older to receive an additional updated 2023-2024 COVID-19 vaccine dose. The recommendation acknowledged the increased risk of severe disease from COVID-19 in older adults, along with the currently available data on vaccine effectiveness. Previous CDC recommendations ensured that people who were immunocompromised were already eligible for additional doses of the COVID-19 vaccine. Data continued to show the importance of vaccination to protect those most at risk for severe outcomes of COVID-19. An additional dose of the updated COVID-19 vaccine may restore protection that has waned since a fall vaccine dose, providing increased protection to adults ages [AGE] years and older. The clinical records for Resident #10, Resident #19, Resident #22, Resident #27, and Resident #29 lacked documentation they, or their responsible party had been educated on the 2023-2024 COVID-19 vaccination, been offered, or received even 1 dose of the vaccine. On 3/12/24 at 6:21 p.m. the Director of Nursing (new to this facility) stated the newest COVID-19 vaccine was not available (to them) until January and they are getting on that. They were evacuated in January to a sister facility and returned to the facility 2/1/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 1304 South Market, Lake Park, IA 51347	

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/24 at 9:54 a.m. the Administrator stated they were in COVID outbreak from late December into January, but all were out of quarantine when they evacuated 1/17/24 to a sister facility. Their pharmacy closed 2/17/24 and she thought they had a week notice. She said they did not look for any other avenues for procuring the vaccine such as public health or other pharmacy. The CDC's Stay Up to Date with COVID-19 Vaccines, updated March 7, 2024, documented: The CDC recommended the 2023-2024 updated COVID-19 vaccines to protect against serious illness from COVID-19. Everyone aged 5 years and older should get 1 dose of an updated COVID-19 vaccine to protect against serious illness from COVID-19. People who were moderately or severely immunocompromised may get additional doses of the updated COVID-19 vaccine. People aged [AGE] years and older who received 1 dose of any updated 2023-2024 COVID-19 vaccine should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months after the previous updated dose. People who were up to date had a lower risk of severe illness, hospitalization and death from COVID-19 than people who were unvaccinated, or who had not completed the doses recommended for them by CDC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 South Market Lake Park, IA 51347	

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. 44475 Based on observation, facility policy, and staff interview, the facility failed to securely attach handrails in the hallways of the facility. The facility reported a census of 29 residents. Findings include: Observation on 3/11/24 at 1:30 PM of an area of handrail where the wood piece attached to the hallway wall to secure the handrail to was separated from the wall by 1/4 inch. When the handrail was tested for securement, the handrail rocked up and down. In a concurrent facility tour and interview on 3/13/24 at 3:08 PM, Staff D, Maintenance Director, reported that he performs monthly checks to determine how secure handrails are and repaired them when found loose. Staff D tested the handrail in question for securement and agreed that it needed repair. The Facility Inspection - Handrails with a task performed date of 3/19/24 directed, in pertinent part, that handrail bracket shall be tightly secured to the wall and to withstand without failure, a force of 200 lbs. (pounds) applied in a downward or outward direction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Aspire of Lake Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 1304 South Market, Lake Park, IA 51347	

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 26527 44475 Based on observation, facility policy, pest control interview, and staff interview, the facility failed to provide an effective pest control program for flies. The facility reported a census of 29 residents. Findings include: Observation on 3/12/24 at 12:30 PM of Resident #26 swatting a fly away from landing on her face. Observation 3/13/24 at 6:00 PM of a fly on the inside of the aluminum foil used to cover the ambrosia salad served during evening meal service. Observation on 3/14/24 at 8:00 AM of a fly inside an open bag of brown sugar in the kitchen. In an interview on 3/13/24 at 10:49 AM, the Administrator and Staff D, Maintenance Director, reported that when manure is spread on the fields of their rural farming community, increased number of flies become problematic. When these times of the year occur, the Administrator reported that the facility's pest control service provided treatment for the flies issue and that pest control company provided service to the building this week, but did not know if treatment included flies. Staff D reported that he attempted to find places in the building in which flies could enter and repaired them as they are found and that there was increased traffic from the doors in the facility this week. When asked if flies could enter the building through gaps in windows, Staff D agreed. In an interview on 3/19/24 at 8:09 AM, Staff 0, pest control staff, reported that the facility does not have a contract to supply specific services for flies. The pest control company is not able to spray chemicals for flies inside the facility and the product they are able to provide is a system in which light would attract flies with glue traps inside the light to trap and kill flies. Staff O reported that the facility does not have this specific service. The Environmental/Plant Operations Policy dated March 2016 directed: 1. The facility strives to protect the residents, staff, and visitors from insects and other pests by controlling infestation through contracts with outside pest control agencies. It is the responsibility of all staff members to detect and report immediately the presence of pests to their supervisor. 2. Procedure to contract with a pest control agency. 3. Evaluate effectiveness of services and contact pest control agency if additional services are needed.