

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2024
NAME OF PROVIDER OR SUPPLIER  Aspire of Washington		STREET ADDRESS, CITY, STATE, ZIP CODE  601 E Polk St Washington, IA 52353	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26529</p> <p>Based on observation, record review, and staff and resident interviews, the facility failed to ensure all residents received adequate nursing supervision that ensured resident safety when the Maintenance Director provided a cognitively impaired resident (Resident #3) with an electric reciprocating saw (a Sawzall) to use outside the facility. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>The Annual 12/22/23 Minimum Data Set (MDS) Assessment tool revealed Resident #3 had diagnoses that included hypertension (high blood pressure), peripheral vascular disease, anxiety, psychotic disorder, Alzheimer's disease and dementia, scored 12 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated mild cognitive impairment, and staff supervision required to ensure resident safety.</p> <p>The Care Plan for Resident #3 with revision date of 12/27/22 documented as follows;</p> <p>a. A Potential for Impaired Cognitive Function and Impaired Thought Process Related to Dementia problem initiated 4/9/19 on the resident's Nursing Care Plan directed staff:</p> <ol style="list-style-type: none"> <li>1. Use task segmentation to support short-term memory deficits.</li> </ol> <p>b. A History of Physical and Verbal Aggression Related to Dementia problem initiated 1/25/17 on the resident's Nursing Care Plan directed staff:</p> <ol style="list-style-type: none"> <li>1. Notify physician and family when resident has outbursts, document in the resident's record.</li> <li>2. Modify environment, adjust room temperature to comfortable level, reduce noise, dim lights, shut door, etc.</li> <li>3. Monitor, document and report any resident actions that pose a threat to the resident's safety, or safety of other residents.</li> <li>4. When resident becomes agitated, intervene before agitation escalates.</li> </ol> <p>Staff interviews revealed:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/21/24 at 9:23 a.m., Staff C, Certified Nursing Assistant (CNA) stated the Maintenance Director (Staff A) gave Resident #3 an electric saw and directed him to trim bushes outside the facility. The Director of Nursing (DON) had to get the saw away from the resident.</p> <p>On 3/28/24 at 1:48 p.m., Staff B, Licensed Practical Nurse (LPN) stated recently when they supervised residents outside on their cigarette break, they heard the sound of an electric saw, looked over and saw Resident #3 trimmed the [NAME] with it, called the DON inside the building from their cell phone, the DON came outside immediately, took the saw away from the resident and said something to the Maintenance Director about it.</p> <p>On 3/28/24 at 1:57 p.m., the DON stated staff told her the Maintenance Director gave Resident #3 a Sawzall, she went outside and observed the resident as he operated the Sawzall, told the resident he couldn't have it and the resident threw the Sawzall to the ground while it was still on as she attempted to take it away from him. The DON stated residents should not have access to hazardous machinery and she had no idea why the Maintenance Director would have given the resident the tool to use.</p> <p>During an interview 3/28/24 at 7:34 a.m., Resident #3 stated he liked to garden and work outside, the Maintenance Director gave him an electric saw to use to trim some bushes, which he was able to do until the DON took the saw away from him. The resident called the DON a foul name as he recalled the event.</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>26529</p> <p>Based on facility record review, staff interviews, and utility company interviews, the facility failed to effectively manage payments of utilities to avoid disconnection notices. The facility administrator and corporate administration failed to pay the gas and electric bill timely and in sufficient amounts which resulted in a scheduled disconnect of services 3/25/24 which was abated after the State Survey Agency prompted the corporation's immediate payment. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>Review of the facility gas and electric (combined) utility bills revealed:</p> <p>A bill dated 2/15/24 documented a previous balance of \$5,547.63, no payment received, current charges of \$4,561.93, with a total of \$10,109.56 due by 3/6/24.</p> <p>A bill dated 3/15/24 documented a previous balance of \$10,109.56, a \$5,547.63 payment received, current charges of \$4,913.62, with a total of \$9,475.55 due by 4/4/24.</p> <p>Staff interviews revealed:</p> <p>On 3/20/24 at 6:21 p.m., Staff D, former facility Scheduler, stated the facility received bill collection types of phone calls from the utility company. Staff D stated she never saw a utility bill come through the mail at the facility, and the previous Administrator stated the facility's utilities would be shut off because the corporation wasn't paying the bills.</p> <p>On 3/21/24 at 10:48 a.m., staff at the facility's utility company stated they had not received any payment since the \$5,547.63 payment received on 2/28/24. The utility company reported the facility was past due on their account, the process to disconnect the facility from service was initiated on 3/20/24, and the disconnection could occur at any time.</p> <p>On 3/21/24 at 11:15 a.m., the facility Administrator stated she had no knowledge of any disconnection notice or the utility's scheduled disconnection due to nonpayment of the bill.</p> <p>On 3/21/24 at 12:09 p.m., the facility Administrator stated she spoke with fiscal staff at the corporate office, and they had paid the past due balance of \$4,561.93; the facility was scheduled for disconnection on 3/25/24, but no longer at risk for disconnection with the past due balance paid.</p> <p>On 3/28/24 at 8:09 a.m., Staff E, Housekeeper, stated the previous Administrator told her the gas and electric were going to be disconnected because the owners weren't paying the bills.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 3/28/24 at 8:27 a.m., staff at the facility's utility company stated the facility's utility bill was mailed to the corporation at an address in Florida. The utility company reported an automated phone call placed on 3/20/24 at 7:02 p.m. to notify the facility that payment was required to avoid service disruption. The utility company placed another phone call on 3/21/24 at 9:15 a.m. to inform the facility that utilities would be disconnected if payment wasn't received and the staff member who answered stated they would notify the facility Administrator. The facility had received disconnection notices for 5 of the last 6 months because they failed to pay the required balances by the posted due dates, a payment of \$4,561.93 was received on 3/21/24, and the facility still owed \$4,913.62, which was due by 4/4/24.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>26529</p> <p>Based on observation, record review, and resident and staff interviews, the facility failed to maintain a safe, functional and sanitary environment for residents, staff and the public, demonstrated by the failure to restore a residential hallway to an inhabitable area after a sewer pipe backed up and caused extensive damage to the floor of the hall and surrounding resident room, that occurred over a year prior, and failed to maintain facility grounds in an orderly way, free of refuse and unsightly items. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>Observations revealed:</p> <p>On 3/21/24 at 7:58 a.m., doors to the 200 Hall (east hall towards the front of the facility) locked, the bottom of the doors were approximately 1 inch above the floor and permitted a foul odor to enter the area by the door in the facility's Dining Room. When the doors were opened, there was a pungent foul sewer smell in the hall, surrounding area and resident rooms. Carpet in the hall was heavily stained, and some areas on the carpet appeared white, similar to the effects from bleach. Several tiles (at least 9 or more) in at least 6 of the resident rooms were lifted from the floor, broken or warped, and required replacement. Rooms on the hall were filled with unusable furniture and equipment, 1 of the rooms filled with at least 16 boxes of biohazard red bag trash with an extremely foul odor, and the 200 Hall that contained some of the facility's licensed beds was uninhabitable.</p> <p>On 3/21/24 at 8:41 a.m. observation revealed a broken toilet located on the ground by a shed located on the facility property, the shed located approximately 100 feet from the facility's garbage dumpster.</p> <p>On 3/21/24 at 9:23 a.m. observation revealed at least 12 bags of biohazard red bag trash with a foul odor located in a Biohazard Room located in the center hall.</p> <p>On 3/28/24 at 6:49 a.m. observation revealed the broken toilet remained in the same position on the ground by the shed, and at least 3 boxes used for biohazard trash had blown in the wind and were located on the grounds near the shed and against a fence at the southern boundary of the facility's property.</p> <p>On 3/28/24 at 7:33 a.m. observation revealed extensive water damage to the ceiling Resident #3's room, the area measured approximately 36 inches by 48 inches in size, and a section of drywall removed from the resident's bathroom that measured approximately 9 inches wide by 36 inches high and exposed the pipes in the wall. The resident in his room at the time stated the wall and ceiling had been that way for several months, staff told the resident he would have to change rooms and he didn't want to relocate to another room.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 3/28/24 at 7:41 a.m. with Staff F, Certified Medication Aide (CMA), revealed the doors to the 200 Hall remained locked, upon entering the hall the carpet had been removed from the hallway, there wasn't a strong sewer smell, the biohazard trash was removed from the resident room, but the resident rooms and tiled floors otherwise unchanged in appearance from the previous observation.</p> <p>On 3/28/24 at 1:59 p.m., the Administrator stood in the center hall by the service hall door and stated the Housekeeping/ Laundry Supervisor was going to assist her to put the broken toilet located by the shed into the facility dumpster, the Maintenance Director instructed her that it could be placed in the dumpster and didn't require a special garbage pick-up.</p> <p>On /28/24 at 3:48 p.m. observation revealed all repairs to the ceiling and bathroom wall in Resident #3's room had been completed by Staff A, the Maintenance Director.</p> <p>Staff interviews revealed:</p> <p>On 3/21/24 at 11:15 a.m., the Administrator stated it was her 3rd day in the facility, on her 1st day there she hadn't noticed the strong sewer smell near the 200 Hall locked doors, but she detected the smell when she stood in the Dining Room by the doors on her 2nd day there. The Administrator was unaware of the length of time the resident hall had been in that condition and would discuss the matter with Staff A.</p> <p>On 3/27/24 at 12:55 p.m., the Administrator stated she directed Staff A to remove the carpet from the 200 hall, that was completed on 3/22/24 with some additional cleaning of the hallway floor and the sewer smell no longer there since the carpet was removed.</p> <p>On 3/28/24 at 9:40 a.m., Staff A stated the previous Administrator directed him to remodel resident rooms in the 100 Hall (West Hall located towards the front of the facility), that was the priority. Staff A stated the sewer line had backed up in the 200 Hall over a year ago, they attempted repairs at the time and thought the sewer line was operable, he asked the previous Administrator about the additional repairs required for the 200 Hall and was directed to remodel rooms in the 100 Hall. Staff A stated he was directed by the current Administrator to remove the carpet from the 200 Hall, which he completed the week before. Staff A stated there was a leaking pipe in Resident #3's bathroom, due to a leaking water spigot located on the outside wall of that room for a hose, that had occurred at least 4 months earlier, he asked the previous Administrator about repairs of the room and was directed to focus on the 100 Hall.</p> <p>On 4/2/24 at 11:44 a.m., the facility corporation President stated it was the responsibility of the facility Administrator to direct the repair and maintenance of damage to the 200 Hall from the backed up sewer line, he had visited the facility prior to winter and was unaware of the damages to the 200 Hall.</p> <p>In an email dated 4/2/24 at 12:34 p.m., the Regional [NAME] President of Operations described the facility did not have a maintenance policy, and utilized the TELS system for maintenance operations, a software system that assists personnel to prioritize required maintenance and utilized a vendor system for the completion of required repairs.</p>		