STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Washington	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48888 Based on observation, interviews with resident, family, and staff, clinical record review, and facility policy review, the facility failed to ensure residents were treated with dignity and respect, when staff used inappropriate language and derogatory remarks towards 1 of 2 residents reviewed for dignity (Resident #28). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 04/19/24, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicative of severe cognitive impairment. Resident #28 had impairment of both upper and lower extremities and had required substantial to maximal staff assistance with dressing, bathing, and toileting cares. Diagnoses included: anoxic brain damage, Type 1 Diabetes Mellitus, Cerebrovascular accident (CVA), depression, and malnutrition. The Care Plan focus area, created 12/14/23, revealed that Resident #28 stated he wished to die. Resident #28 had a communication problem related to head injury and encouraged to continue to state thoughts, even when having difficulty. Staff are instructed to speak to Resident #28, clearly and on an adult level. The Care Plan additionally revealed Resident #28 had impaired cognitive function or impaired thought processes and agitated behaviors related to diagnosis of anoxic brain injury, which instructed staff to provide opportunities for positive interaction. The Care Plan focus area, created 03/07/24, revealed Resident #28 made false accusations against staff related to disease process, instructed that two staff are to be present when care is provided, and staff to report any accusation to Director of Nursing (DON) and Administrator immediately. On 05/07/24 at 09:03 AM, within close hearing distance, staff could be heard loudly making the statements, You will go to jail!, You are going to go to jail!, It's not fair for you to be swinging on us, you will go to jail!. Observed Staff A, Certified Nursing Assistant (CNA), transport Resident #28, via wheelchair, out of 600 hallway shower room to Resident #28's room, as she made loud statements, with irritated tone of voice, to Resident #28 about him going to jail. A second CNA, Staff B, exited 600 hallway shower room and informed that Staff A had made the comments heard from hallway to Resident #28. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/24 at 09:35 AM, the facility's Nurse Consultant informed that the incident between Staff A and Resident #28, on 05/07/24 at 09:03 AM, would be a self-reported incident with facility investigation and submission to the Department of Inspections, Appeals, and Licensing (D.I.A.L.). Nurse Consultant informed that Staff A would be placed on suspension. On 05/07/24 at 10:48 AM, facility submitted a self-reported incident of alleged abuse to D.I.A.L. intake office. Incident summary indicated that Staff A, CNA, threatened, cursed at, and threw a blanket at Resident #28 with Staff B, CNA, present. According to the facility reported incident, Staff A used profanity and cursed at Resident #28. Facility interviews revealed Staff A stated she would not help lay resident down and that she was going home. Resident #28 asked why she wouldn't help and raised his fist, Staff A responded with the statements heard from hallway that Resident #28 would go to jail if he hit her. The facility interviewed Resident #28 following incident, resident informed that he and Staff A do not get along and that Staff A threw a blanket at him. The intake concluded that Staff A had been suspended pending investigation. In a witness statement, signed and dated by Staff B, CNA, on 05/07/24, Staff A and B had given Resident #28 a shower. According to statement, Staff B informed Staff A they would need to lay resident down after shower, Staff A cursed, stated she was going home, and stated she would not lay Resident #28 down. Resident #28 then asked why Staff A would not help and raised his fist, in response Staff A told resident if he hit her he would go to jail. On 05/08/24 at 01:00 PM, Staff B, CNA, stated that on multiple different occasions in the presence of Resident #28, Staff A, CNA, would call Resident #28 names, such as retard, use profanity towards or around resident, and irritate him. Staff B additionally reported Staff A had, on more than one occasion, taken Resident #28's cell phone and put it on top shelf of closet with the knowledge that he would be unable to reach due to inability to stand and had reported these concerns to the Director of Nursing (DON). On 05/08/24 at 02:14 PM, Social Services Director stated that Staff A, CNA, had been heard using profanity around residents in general and talked about things she shouldn't at times in the nurse's station, but had not heard Staff A use profanity or curse directly at a resident. Social Services Director stated that interactions seen between Staff A and Resident #28 were joking with one another. Social Services Director denied ever hearing about Staff A calling Resident #28 names or placing his cell phone out of reach but stated this would not be acceptable. On 05/09/24 at 09:50 AM, Staff E, CNA, stated that Resident #28 keeps his cell phone in a bag around his neck at all times unless it is being charged on a countertop, so resident can get to it. Staff E noted that on more than one occasion, when Resident #28 stated he could not find cell phone, she had found it on the top shelf of the closet. Staff E reported asking multiple staff members who worked these days, including Staff A, why his cell phone was in the closet and stated, no one had an answer. Staff E stated that Staff A and Resident #28, initially, had joking-types of interactions but changed to more bickering and that Staff A used a lot of sarcasm towards Resident #28, as well as co-workers. Staff E noted that Resident #28 was sensitive and easily got his feeling hurt. Staff E reported overhearing a loud and inappropriate conversation that involved use of profanity between Staff A and Resident #28 from outside the resident's room at the Nurse's Station. Staff E reportedly went into the room and told Staff A, they would report her if this type of interaction was heard again. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/24 at 10:47 AM, Staff D, Licensed Practical Nurse (LPN), stated that Staff A had been heard using inappropriate language and profanity when joking with Resident #28 and that he has had to remind Staff A this was inappropriate. Staff D stated Staff A has an abrupt personality, but had not heard anything negative to the point of a complaint from staff or residents. On 05/09/24 at 02:19 PM, Staff A, CNA, confirmed she often works with Resident #28 and had assisted Resident #28 with shower on 05/07/24 at 09:03 AM. Staff A confirmed making the statements to Resident #28 that he would go to jail if he hit her. Staff A stated after Resident #28's shower, she spoke with the Director of Nursing (DON), about what happened and denied the use of any profanity. Staff A revealed that shortly after speaking to the DON, the Nurse Consultant informed her of suspension. Staff A reported her suspension was due to telling Resident #28 he would go to jail and understood this could be seen as a threat. Staff A stated that Resident #28 is in his right mind and is very aware of what he is doing, Staff A explained that he resided at facility due to contracted legs and inability to walk. Staff A confirmed that calling residents names and use of profanity towards residents is considered verbal abuse, stated that verbal abuse is to be reported to DON or the nurse on duty immediately. Staff A stated she has used profanity around Resident #28 but not towards him, denied ever calling Resident #28 any derogatory names. Staff A revealed that Resident #28 keeps his cell phone in red bag and is unaware of any reason his cell phone would be in the closet. On 05/13/24 at 10:30 AM, Director of Nursing (DON), stated when Resident #28 had been interviewed shortly after the self reported incident had occurred on 05/07/24, he was very upset, and stated that Staff A cursed at him so he pulled his fist back. DON stated that Staff A had been known to use profanity and inappropriate language at the Nurse's Station with residents present, and that Staff A had been educated that inappropriate language is not to be used with residents in the area. DON reported Staff A had not received any disciplinary action prior to suspension. DON denied any complaints received from Resident #28 or staff about Staff A cursing at residents, name calling, or placing his phone on top shelf of closet. On 05/13/24 at 11:55 AM, a family member reported Resident #28 had informed them of a recent incident in which Staff A had cursed at Resident #28 when he had asked for a bath. Family denied Resident #28 voicing any previous concerns about Staff A. On 5/13/24 at 2:26 PM, Resident #28 stated within the last week, Staff A, CNA, had pushed him in the chest, hit him on the forehead, used profanity when telling him to, shut the f- up, and called him a fat bitch. Resident #28 stated that this makes him feel bad and does not make him feel good about himself. Resident #28 stated that Staff A uses the F word all the time and indicated they used to joke around a lot before Staff A started treating him bad. Resident #28 reported that his cell phone is usually kept with him in a red bag but there had been times where he cannot find it or reach it when found in the closet, resident unaware of who put cell phone in the closet. Resident #28 informed that he does not want to be around Staff A. A facility document titled, Position Summary, for Certified Nursing Assistant (CNA), signed by Staff A on 10/31/23, revealed the expectation that all employees are expected to demonstrate proper respect for residents and to assist in resident calls, fall prevention, and advocacy as appropriate. Position summary additionally revealed that employees are expected to communicate clearly, accurately, and respectfully with residents/patients, families, visitors, vendors, and center employees. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Freedom of Abuse, Neglect, and Exploitation Policy, revised 10/2023, revealed a zero tolerance of abuse, of any type or manner, and abuse would be addressed accordingly. Additionally, for all reports of abuse perpetrated by staff, the allegations must not be dismissed based on resident's cognitive status. Policy informed that staff members are expected to be in control of their own behavior and understand how to work with the nursing home population. Listed under the heading, Mental and Verbal Abuse, policy included the following examples: 1. Use of verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. 2. Verbal abuse may be the use of written or gestured, oral, communication or sounds within resident hearing distance. 3. Harassing a resident. 4. Mocking, insulting, ridiculing 5. Yelling or hovering over a resident with intent to intimidate. 6. Threatening residents including depriving residents of care or refraining resident from seeing family. 7. Isolating residents from social interaction.