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	03/20/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35434 Based on observation, clinical record review, policy review, and staff interview, the facility failed to carry out interventions to prevent and/or treat pressure ulcers for 3 of 3 residents reviewed with pressure ulcers (Residents #2, #18, #25). The facility reported a census of 32 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. (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 0686 Level of Harm - Actual harm Residents Affected - Few	1. The 2/7/25 MDS assessment tool listed diagnoses for Resident #18 which included diabetes, non-Alzheimer's dementia, and Parkinson's disease (a disease characterized by tremors, stiffness, and slow movements). The MDS stated the resident was at risk for pressure ulcers but had no unhealed pressure ulcers. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 6 out of 15, indicating severely impaired cognition. The facility policy Pressure Injury/Skin Breakdown-Clinical Guidelines, approved 6/2024, stated staff would implement interventions for the prevention and care of skin issues. A 2/18/25 N Adv-Skin Check note stated the resident had an unstageable pressure ulcer, black in color to the right heel which measured 2 centimeters(cm) x 2.2 cm (length x width). A 2/18/25 Care Plan note stated the resident had an unstageable pressure ulcer to the right heel and directed staff to encourage the resident to take his shoes off while in his room. A 2/20/25 Care Conference Note stated the facility discussed getting slippers for the resident when he sat in the chair. A 2/25/25 N Adv-Skin Check note stated the resident had a unstageable pressure ulcer, black in color to the right heel. A 3/4/25 N Adv-Skin Check note stated the resident had an unstageable pressure ulcer to the right heel, black in color. A 3/5/25 N. Adv Skin Check note stated the resident had a right heel ulcer, black in color, which measured 1. 5 cm x 2.4 cm. A 3/8/25 N Adv Skin Check note stated the resident had a new blood blister to the left heel. The note did not include measurements of the blister. A 3/11/25 N Adv-Skin Check note stated the resident had a black pressure ulcer on the right heel and a blood blister on the left heel. On 3/17/25 at 3:16 p.m., the resident stated he had wounds on both of his heels. He stated when he was in bed, his heel were directly on the mattress and he did not wear boots or utilize pillows to offload his heels. On 3/18/25 at 8:38 a.m. and 9:13 a.m., the resident laid in bed on his back and his heels laid directly on the mattress. On 3/19/25 at 9:13 a.m. Staff B, Licensed Practical Nurse (LPN) measured a round dry-appearing dark-colored wound to his right inner heel as 3 cm x 2.5 cm. The State Agency (SA) asked to see the left heel and Staff B stated she was not aware he had an area on his left heel. She measured a dark red blister on the resident left heel as 5 cm x 5 cm. Staff E, LPN was present during the observation and asked the resident if he would be willing to wear boots in bed if she provided them and he said he would. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility lacked physician notification of the resident's left heel blister from the 3/8/25 date of discovery until 3/19/25 and lacked documentation of a treatment carried out on the area from 3/8/25 to 3/19/25. The resident's Care Plan lacked further interventions to treat his right heel pressure ulcer and interventions to prevent the development of new ulcers. The Care Plan lacked guidance for staff regarding ways to reduce pressure on the resident's heels. The facility lacked further documentation of providing the resident slippers from the 2/18/25 note until 3/18/25. On 3/19/25 at 3:42 p.m., Staff B, LPN stated she started completing the facility's skin checks last week and stated she was not aware of Resident #18's left heel wound. She stated there was no order for the left heel as of today and stated she would suggest he placed a pillow underneath him for offloading. 2. The 2/15/25 MDS assessment tool listed diagnoses for resident #2 which included quadriplegia (paralysis from the neck down), encounter for change or removal of a nonsurgical wound dressing, and weakness. The MDS stated the resident required substantial/maximal assistance for turning right and left and stated the resident was at risk of developing pressure ulcers/injuries and had 1- Stage 4 pressure ulcer. The MDS listed the resident's cognitive skills as modified independence (some difficulty in new situations only). A 3/19/24 Care Plan entry stated the resident had a Stage 4 pressure ulcer of the coccyx. A 10/1/24 Care Plan entry stated the resident should not sit up in her wheelchair longer than 2 hours related to wound healing. The Care Plan lacked guidance for staff to assist the resident to turn from side to side. On 3/17/25 at 2:20 p.m., the resident laid in bed on her back and her air mattress was on the setting static. She stated she had a new area on her bottom which the Certified Nursing Assistants (CNAs) discovered. She stated she did not roll from side to side but would be willing to if staff assisted her. A 3/17/25 Health Status Note stated CNA's reported a new open area to the resident's buttocks which measured 0.5 cm x 1.0 cm and the facility informed the provider and applied barrier ointment. On 3/18/25 at 3:38 p.m., Staff C LPN measured a wound on the resident's sacrum as 1.2 cm x 0.9 cm x 3.4 cm which had a red wound bed. The resident also had a red, open area on her right lower buttock approximately the size of a quarter. The area had no dressing affixed to it. Staff C stated he did not have orders for this area yet. The resident's air mattress was set to static. The March 2025 Treatment Administration Record (TAR) lacked documentation of a treatment initiated to the resident's right buttock wound from the day of discovery on 3/17/25 until 3/20/25. The facility lacked documentation that the resident was on a turning and repositioning program. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/20/25 at 10:40 a.m., Resident #2's air mattress was set on static. The MDS Coordinator stated it should be on alternating and changed it to the air redistribution setting. On 3/20/25 at 11:03 a.m. Staff A CNA stated Resident #2 was on a turning and repositioning program. She stated she had an alternating mattress and when it was on the repositioning setting, this would take care of her turning and repositioning. She stated she would not want to position her on her side while the mattress was set on the redistribution setting as the resident could fall out of bed. 3. The 2/22/25 MDS assessment tool listed diagnoses for Resident #25 which included paraplegia (paralysis from the waist down), depression, and psychotic disorder. The MDS stated the resident was at risk for developing pressure ulcers and had 2 unstageable pressure ulcers. The MDS listed his BIMS score as 13 out of 15. 9/4/24 Care Plan entries stated the resident had a pressure injury and directed staff to carry out treatments as ordered. The March 2025 TAR listed a 2/14/25 order for Mupirocin External Ointment 2%(a medication which prevented bacterial growth in wounds) to the right and left buttock topically at bedtime for left and right ischial(referring to the lower portion of the hip bone) wounds. A 3/11/25 Medication Administration Note stated the resident's Mupirocin External Ointment was not available and staff waited for pharmacy delivery. A 3/12/25 Medication Administration Note stated the facility was out of the resident's Mupirocin ointment and waited for the pharmacy to deliver. On 3/19/25 at 8:44 a.m., Staff B LPN measured a wound on the left hip as 5 cm x 5 cm and a wound on the right buttock as 4 cm x 4.5 cm. The left hip wound had a brown, pink, and white wound bed and the right buttock had a pink wound bed. Staff B applied Mupirocin ointment to both wounds. On 3/19/25 at 3:53 p.m., the Director of Nursing (DON) stated it would depend on the resident, but they would implement such interventions as position changes, boots, offloading, and gel pads to treat and prevent heel ulcers. He stated if staff discovered a new skin area, they would notify the provider and obtain orders as soon as possible. He stated he did not know about Resident #18's left heel wound.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35434 Based on observation, clinical record review, policy review, and staff interview, the facility failed to carry out appropriate safety interventions for 1 of 3 residents reviewed for smoking safety (Resident #25). The facility reported a census of 32 residents. Findings Include: 1. The 2/22/25 Minimum Data Set(MDS) assessment tool listed diagnoses for Resident #25 which included paraplegia(paralysis from the waist down), depression, and psychotic disorder. The MDS stated the resident had impairment in range of motion(ROM) in both upper extremities and listed his Brief Interview for Mental Status(BIMS) score as 13 out of 15. The facility F 689 F 926 Accident Prevention-Smoking Policy, approved 8/2024, stated the facility would establish and maintain safe resident smoking practices. The 10/12/24 N Adv- Smoking and Safety Assessment stated the resident had limited or no ROM in arms or hands and dropped ashes on himself. A 2/28/25 Care Plan entry stated the resident required an apron while smoking. The 3/12/25 Smoking and Safety Assessment stated the resident had limited ROM in arms or hands and must wear a smoking apron. On 3/18/25 at 4:09 p.m. Resident #25 sat outside in the courtyard and smoked without wearing a smoking apron. On 3/19/25 at 4:04 p.m., the Administrator stated the resident should wear a smoking apron due to falling ashes. On 3/20/25 at 11:03 a.m. Staff A Certified Nursing Assistant(CNA) stated she assisted residents during their smoking breaks. She stated Resident #25 was required to wear a smoking apron and there was a list which directed staff to do this.