STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Sutherland	506 East Fourth Street Sutherland, IA 51058

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 1 out of 3 residents reviewed from physical abuse, (Resident #2). The facility reported a census of 21 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of the facility Incident Report dated 7/12/24 at 12:06 p.m., revealed incident description Resident #2 stated that Staff C, Certified Nursing Assistant (CNA) slapped her on the hands when she asked for a pop. Review of Resident #2 ' s Progress Notes revealed on 7/12/24 at 12:10 p.m., Resident stated that Staff C, CNA slapped her on the hands when she asked her for a pop. Interview on 8/4/24 at 10:17 a.m., with Resident #2 revealed she had asked Staff C for another pop and Staff C said Resident #2 was yelling at her and not to yell at her. Staff C told Resident #2 she could not have another pop and started slapping her hands. Resident #2 revealed she told Staff C to stop and Staff C did not stop slapping her hands. Interview on 8/2/24 at 3:18 p.m., with Staff D, Licensed Practical Nurse (LPN) revealed she came in after the incident occurred on 7/11/24. Staff D had received report from the nurse leaving and heard about what Resident #2 had reported. Staff D asked Resident #2 what happened and Resident #2 revealed Staff C had slapped her hand. Staff D went down later in her shift and noted Staff C was in Resident 2 ' s room assisting her. Staff D told Staff C she was not supposed to be assisting Resident #2 and asked her to leave Resident #2 ' s room. Interview on 8/2/24 at 4:49 p.m., with the Administrator revealed when he came into work the morning of 7/12/24 the staff told him what Resident #2 had reported to Staff E, CNA that Staff C had slapped her on the hands when she asked for another pop. The Administrator continued after he found out, he went and talked to Resident #2. Resident #2 told him she thought Staff C was mad at her for asking for another pop and Staff C slapped Resident #2 on the hands. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Sutherland		STREET ADDRESS, CITY, STATE, ZIP CODE 506 East Fourth Street Sutherland, IA 51058	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/2/24 at 5:07 p.m., with the Director of Nursing (DON) revealed she was told by another staff member on 7/12/24 Resident #2 told her Staff C slapped her hands. She proceeded to go and talk to Resident #2. Resident #2 revealed she had asked Staff C to get her another pop and Staff C said no and slapped Resident #2 on her hand. Interview on 8/4/24 at 9:32 a.m., with Staff E revealed she was assisting Resident #2 at approximately 6:30 a. m. on 7/12/24, with getting up and Resident #2 told her Staff C had slapped her hand. Staff E reported to Staff F, LPN. Interview on 8/4/24 at 12:38 p.m., with Staff F revealed she was working on the morning of 7/12/24 when Staff E reported to her Resident #2 revealed Staff C had slapped her hands. Staff F went in and talked to Resident #2 and asked her about the situation. Staff F revealed Resident #2 stated it was during suppertime the night before when Staff C slapped her hands. Staff F couldn ' t remember what time she reported it to the DON but knows Staff E reported it to her and it was early. She did not call the DON right away but told her in person when she arrived at the facility. Review of the facility provided policy titled Freedom of Abuse, Neglect and exploitation; Abuse Prevention: Fast Alerts dated August 2022 revealed the following: a. Purpose of this written Freedom of Abuse, Neglect, Exploitation; Abuse Prevention Standard is to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment and neglect of residents and the misappropriation of resident property and to review practices and omissions which if allowed to go unchecked, could lead to abuse. This standard demonstrates a zero tolerance of abuse of any type or manner and will be addressed accordingly. b. Person Centered Care- to focus on the resident as the focus of control and support in making their own choices and having control over their daily lives. c. Staff to Resident Abuse- the facility is responsible for the actions of its employees, including intentional acts by employees who are aware they are doing something wrong and are in conflict with the facility's policies and procedures. d. Staff members are expected to be in control of their own behavior and understand how to work with the nursing home population. Interview on 8/2/24 at 5:07 p.m., with the DON revealed she explained to staff the residents have rights and the resident can pick and choose what they want. If they want something they can have it, she should not have refused the pop to Resident #2.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 1 of 1 residents reviewed for abuse (Resident #2). The facility reported a census of 21 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of the facility Incident Report dated 7/12/24 at 12:06 p.m., revealed incident description Resident #2 stated that Staff C, Certified Nursing Assistant (CNA) slapped her on the hands when she asked for a pop. Interview on 8/2/24 at 3:18 p.m., with Staff D, Licensed Practical Nurse (LPN) revealed she came in after the incident occurred on 7/11/24. Staff D had received report from the nurse leaving and heard about what Resident #2 had reported. Staff D asked Resident #2 what happened and Resident #2 revealed Staff C had slapped her hand. Staff D went down later in her shift and noted Staff C was in Resident 2 ' s room assisting her. Staff D told Staff C she was not supposed to be assisting Resident #2 and asked her to leave Resident #2 ' s room. Interview on 8/2/24 at 4:49 p.m., with the Administrator revealed when he came into work the morning of 7/12/24 the staff told him what Resident #2 had reported to Staff E, CNA that Staff C had slapped her on the hands when she asked for another pop. The Administrator continued after he found out, he went and talked to Resident #2. Resident #2 told him she thought Staff C was mad at her for asking for another pop and Staff C slapped Resident #2 on the hands. Interview on 8/2/24 at 5:07 p.m., with the Director of Nursing (DON) revealed she was told by another staff member on 7/12/24 Resident #2 told her Staff C slapped her hands. She proceeded to go and talk to Resident #2. Resident #2 revealed she had asked Staff C to get her another pop and Staff C said no and slapped Resident #2 on her hand. Interview on 8/4/24 at 9:32 a.m., with Staff E, CNA revealed she was assisting Resident #2 at approximately 6:30 a.m. on 7/12/24, with getting up and Resident #2 told her that Staff C had slapped her hand. Staff E reported to Staff F, LPN. Interview on 8/4/24 at 12:38 p.m., with Staff F revealed she was working on the morning of 7/12/24 when Staff E reported to her Resident #2 revealed Staff C had slapped her hands. Staff F went in and talked to Resident #2 and asked her about the situation. Staff F revealed Resident #2 stated it was during suppertime the night before when Staff C slapped her hands. Staff F couldn ' t remember what time she reported it to the DON but knows Staff E reported it to her and it was early. She did not call the DON right away but told her in person when she arrived at the facility. (continued on next page)

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	165458	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Sutherland	506 East Fourth Street Sutherland, IA 51058

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility intake information the facility submitted a self report on 7/12/24 at 11:17 a.m. Review of the facility provided policy titled Freedom of Abuse, Neglect and exploitation; Abuse Prevention: Fast Alerts dated August 2022 under Overview reporting revealed: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property are reported immediately, but no later than 2 horse after the allegation is made, if the events that cause the allegation involve abuse. b. The Administrator or designee will report such findings to the State Licensing agency with-in 2 hours of the event. Interview on 8/5/24 at 12:24 p.m., with the DON revealed she was unaware of the time frame for reporting an abuse allegation.

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F 0610

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44474

Based on clinical record review, facility investigation review, staff and resident interviews, and facility policy review the facility failed to ensure residents were protected from further potential abuse after receiving an allegation of abuse. On 7/11/24, the nurse learned of a Certified Nurse Aide (CNA) slapping Resident #2 on the hands. After learning of this allegation of abuse, the facility allowed the CNA to finish working the scheduled shift and to continue to work unattended behind closed doors with other residents. This failure resulted in residents living at the facility to be exposed to the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of July 11, 2024 on August 4, 2024 at 2:32 p.m The facility staff removed the IJ on August 4, 2024 through the following actions:

a. All staff were educated on reporting of allegations of abuse to the Administrator and Director of Nursing (DON) immediately on August 4th, 2024.

b. All Staff were educated on types of abuse and the protection of residents on August 4, 2024.

c. Education was provided to the CNA who knew about the potential allegations of abuse, who did not report the situation to the Administrator and/or DON.

d. The CNA who is alleged to have slapped the resident on the hand has been suspended on August 4th, 2024 pending a comprehensive investigation.

e. Administrator or Designee will audit weekly, three residents on if there are any concerns regarding allegations of abuse. This will continue for four weeks and be brought to the QAPI meeting.

e. Ad hoc QAPI meeting will be held and reviewed on August 5th, 2024.

f. The Medical Director was notified of the event on August 4th, 2024.

The scope lowered from a K to E at the time of the survey after ensuring the facility implemented education and their policy and procedures.

The facility identified a census of 21 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.

Review of the facility Incident Report dated 7/12/24 at 12:06 p.m., revealed incident description Resident #2 stated that Staff C, CNA slapped her on the hands when she asked for a pop.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2 ' s Progress Notes revealed on 7/12/24 at 12:10 p.m., Resident stated Staff C, CNA slapped her on the hands when she asked her for a pop. Interview on 8/2/24 at 3:18 p.m., with Staff D, Licensed Practical Nurse (LPN) revealed she came in after the incident occurred on 7/11/24. Staff D had received report from the nurse leaving and heard about what Resident #2 had reported. Staff D asked Resident #2 what happened and Resident #2 revealed Staff C had slapped her hand. Staff D went down later in her shift and noted Staff C was in Resident 2 ' s room assisting her. Staff D told Staff C she was not supposed to be assisting Resident #2 and asked her to leave Resident #2 ' s room. Interview on 8/2/24 at 4:49 p.m., with the Administrator revealed when he came into work the morning of 7/12/24 the staff told him what Resident #2 had reported to Staff E, CNA that Staff C had slapped her on the hands when she asked for another pop. The Administrator continued after he found out, he went and talked to Resident #2. Resident #2 told him she thought Staff C was mad at her for asking for another pop and Staff C slapped Resident #2 on the hands. Interview on 8/2/24 at 5:07 p.m., with the Director of Nursing (DON) revealed she was told by another staff member on 7/12/24 Resident #2 told her Staff C slapped her hands. She proceeded to go and talk to Resident #2. Resident #2 revealed she had asked Staff C to get her another pop and Staff C said no and slapped Resident #2 on her hand. Interview on 8/4/24 at 9:32 a.m., with Staff E, CNA revealed she was assisting Resident #2 at approximately 6:30 a.m. on 7/12/24, with getting up and Resident #2 told her that Staff C had slapped her hand. Staff E reported to Staff F, LPN. Interview on 8/4/24 at 12:38 p.m., with Staff F revealed she was working on the morning of 7/12/24 when Staff E reported to her Resident #2 revealed Staff C had slapped her hands. Staff F went in and talked to Resident #2 and asked her about the situation. Staff F revealed Resident #2 stated it was during suppertime the night before when Staff C slapped her hands. Staff F couldn ' t remember what time she reported it to the DON but knows Staff E reported it to her and it was early. She did not call the DON right away but told her in person when she arrived at the facility. Review of Staff C ' s time sheet revealed the following information: 7/11/24 punched in at 3:35 p.m. and punched out at 10:15 p.m., for a shift total of 6.5 hours worked. Review of the facility provided policy titled Freedom of Abuse, Neglect and exploitation; Abuse Prevention: Fast Alerts dated August 2022 revealed the following: a. If a staff member is accused of abuse by a resident, family member or another staff person, that staff member is suspended pending investigation. If it is determined the allegation is unsubstantiated through investigation, then the staff member is brought back to work and educated as to prevention, identification, reporting of abuse and allowed to continue to work. b. Nursing staff Duties (continued on next page)

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	165458	A. Building B. Wing	08/05/2024

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Aspire of Sutherland	506 East Fourth Street Sutherland, IA 51058

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	i. An incident of an abuse event must be reported to the charge nurse who will examine the resident, document findings and incident report in the clinical record and immediately initiate the investigation protocol. ii. The administrative or nursing supervisor assumes responsibility for immediate notification of the Administrator and the Director of Nursing by phone if necessary, and also notification of the appropriate department head, family, responsible party, and Regional Nurse Consultant. iii. Nursing is to document the resident ' s physical and emotional status every shift for 72 hours following the incident and ensure resident safety. Interview on 8/2/24 at 5:07 p.m., with the DON revealed she expected the first step in an allegation like this is to first separate and make sure the resident is safe. If the allegation is of alleged perpetrator being a staff member then to get that staff member off of the floor and then start the investigation. The staff member should not have been allowed to finish their shift.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on observation, staff interview and facility policy, the facility failed to provide complete and appropriate incontinence care in a manner to prevent urinary tract infections for 1 of 3 residents observed (Resident #5). The facility reported a census of 21 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented diagnoses of cerebral palsy, abnormal posture and muscle wasting and atrophy. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Observation on 8/2/24 at 3:51 p.m., of Staff G, Certified Nursing Assistant (CNA) and Staff H, CNA assisted Resident #5 with perineal care. Resident #5 was incontinent of bowel and bladder. Staff H performed perineal care on the genitals and then moved to the buttocks of Resident #5. On 2 separate occasions Staff H wiped feces from the anus up to the buttocks area with the same part of the disposable wipe 3 times before moving to a clean part of the wipe. Staff H removed soiled gloves and did not perform hand hygiene prior to assisting with applying Resident #5 ' s clean incontinent brief. Interview on 8/5/24 at 12:24 p.m., with the Director of Nursing revealed she would expect staff to use a clean part of the wipe for each wipe during perineal care.