

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Aspire of Estherville		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 First Avenue North Estherville, IA 51334	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>49628</p> <p>Based on record review, staff interview, and policy review the facility failed to notify the Long Term Care (LTC) Ombudsman of a transfer to a hospital for 1 of 2 residents (Resident #190) reviewed. The facility reported a census of 36 residents.</p> <p>Findings include:</p> <p>Review of Resident #190's Clinical Census in the Electronic Health Record (EHR) revealed Resident #190 had a hospital unpaid leave from 10/30/24 to 11/6/24.</p> <p>Review of the facility document, Notice of Transfer Form to Long Term Care Ombudsman, for the month of 10/24 revealed there was no notification for the Resident 190's hospitalization beginning on 10/30/24.</p> <p>During an interview on 12/11/24 at 1:42 PM the Administrator acknowledged Resident #190 was neither on the Discharge Report nor the Notice of Transfer to Long Term Care Ombudsman Report. The Administrator stated the resident had been missed on his transfer to the hospital. The Administrator indicated she completed the Ombudsman notifications.</p> <p>On 12/12/24 at 8:00 AM the Administrator stated the expectation was for residents transferred to acute hospitals to be on the Ombudsman Report.</p> <p>The facility policy titled Transfer and/or Discharge, Including Against Medical Advice last revised 10/22 revealed a copy of the transfer or discharge notice should be sent to the Long Term Care Ombudsman and noted in the record.</p> <p>The facility provided document, The Iowa Health Care Association Protocols for Use and Issuance of Nursing Facility Transfer Notices dated 9/19, revealed copies of notices for emergency transfers must be sent to the Ombudsman, but may be included on a monthly summary.</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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>47079</p> <p>Based on record reviews, staff interviews, and policy review, the facility failed to complete comprehensive assessments within required time frames for 7 of 7 residents (Residents #4, #7, #8, #15, #18, #189, and #190). The facility reported a census of 36.</p> <p>Findings include:</p> <p>On 12/10/24 at 9:31 AM, multiple record reviews revealed seven (7) past-due Comprehensive Assessments (Minimum Data Sets - MDS) and were documented as follows:</p> <ol style="list-style-type: none"> <li>1) Resident #4's MDS included an Assessment Reference Date (ARD - last day of observation period) of 11/04/24 with an in-progress status. It indicated 22 days past due.</li> <li>2) Resident #7's MDS included an ARD of 10/07/24 with an in-progress status. It indicated 50 days past due.</li> <li>3) Resident #8's MDS included an ARD of 11/05/24 with an in-progress status. It indicated 22 days past due.</li> <li>4) Resident #15's MDS included an ARD of 10/14/24 with an in-progress status. It indicated 41 days past due.</li> <li>5) Resident #18's MDS included an ARD of 10/03/24 with an in-progress status. It indicated 54 days past due.</li> <li>6) Resident #189's MDS included an ARD of 10/29/24 with an in-progress status. It indicated 28 days past due.</li> <li>7) Resident #190's MDS included an ARD of 10/03/24 with an in-progress status. It indicated 54 days past due. It also included five (5) other past-due, in-progress MDS assessments with ARDs of 11/06/24, 11/11/24, 11/18/24, and 11/24/24.</li> </ol> <p>The Resident Assessment Instrument (RAI) indicated a resident's MDS assessments must be completed within 14 days from the ARD.</p> <p>A policy titled Comprehensive Assessment revised 08/22 indicated the Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule:</p> <ol style="list-style-type: none"> <li>a) Within fourteen (14) days of the resident's admission to the facility;</li> <li>b) When there has been a significant change in the resident's condition;</li> <li>c) At least quarterly; and</li> </ol> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d) Once every twelve (12) months.</p> <p>On 12/12/24 at 8:01 AM, the Administrator stated she expected Comprehensive Assessments to be completed in a timely fashion.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>49056</p> <p>Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (July 1 - September 30) review, facility staffing reports review, employee time cards review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 36 residents.</p> <p>Findings include:</p> <p>The PBJ Staffing Data Report with run date 12/4/24 triggered for failing to have licensed nursing coverage 24 hours/day - 4 or more days within the quarter with &lt;24 hours/day licensed nursing coverage with specific infraction dates. The report reflected 7 dates with failure to provide 24 hour/day nursing coverage during August and September.</p> <p>Review of the Nurse Schedule for the infraction dates revealed nursing shifts covered by the Director of Nursing (DON), Staff C, Licensed Practical Nurse (LPN), Staff D, LPN, Staff E, Registered Nurse (RN), Staff F, RN, and Staff G, RN for 7/7 dates. Review of time cards for the infraction dates revealed nursing services were provided for 24 hours/day.</p> <p>On 12/11/24 at 2:19 PM the Business Office Manager (BOM) stated she submitted the missed punches to Weblock, then uploaded them into a folder in Teams and then the Corporation would handle it from there.</p> <p>On 12/12/24 at 8:55 AM the Administrator stated during this quarter July 1 - September 30 their previous Corporation took care of submitting hours to PBJ. The Administrator acknowledged that during this period their own staff hours were not being transferred correctly to be submitted to PBJ and the Corporation was aware of this and looking into it.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47079</p> <p>Based on observations, clinical record review, staff interviews, and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during mealtimes, catheter management, and laundry delivery. The facility reported a census of 36.</p> <p>1) On 12/09/24 at 12:11 PM, Staff A, Certified Nurse Aide (CNA) put on a pair of gloves, picked a fork off the floor with her right hand, and placed it on the table. She walked behind a resident (Resident #34) seated in a tilt-chair, repositioned the resident to face the right side of the table, sat down to the right of the resident, and began feeding the resident. She wiped the resident's mouth with a napkin in her right gloved hand, picked up the resident's milk cup from the top with her gloves, and gave the resident some milk. She did not perform hand hygiene or change gloves throughout the process.</p> <p>A policy titled Handwashing/Hand Hygiene revised 10/22 indicated employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under conditions which included before and after assisting a resident with meals.</p> <p>On 12/12/24 at 8:30 AM, the Director of Nursing (DON) stated staff should not pick utensils off the floor then assist a resident to eat.</p> <p>49628</p> <p>2) The Minimum Data Set (MDS) quarterly assessment with completed date 7/9/24, documented Resident #10 had a Brief Interview for Mental Status score of 10/15 indicating moderate cognitive impairment. The MDS documented diagnoses that included hemiplegia for unspecified cerebrovascular disease affecting the right dominant side, diabetes, and a Stage 3 Pressure Ulcer. The assessment section entitled Functional Abilities and Goals (GG) revealed Resident #10 required substantial/extensive assistance with activities of daily living (ADLs), mobility, and transfers. The resident had an indwelling catheter.</p> <p>Resident #10's Care Plan revealed approaches for staff to follow including the resident having a catheter, following Enhanced Barrier Precautions, taking care of catheter equipment, and monitoring of signs/symptoms for urinary tract infections.</p> <p>Observation on 12/10/24 at 12:36 PM revealed Resident #10 self propelling her wheelchair with the catheter bag and tubing dragging on the floor.</p> <p>The facility provided document, Indwelling Urinary Catheters, revealed the catheter tubing and drainage bag were to be kept off the floor.</p> <p>On 12/12/24 at 8:25 AM the Infection Preventionist (IP)/Director of Nursing (DON) stated the expectation would be for catheter bags/tubing to be kept in dignity bags and not on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Administrator on 12/12/24 at 8:00 AM stated the expectation would be for catheter tubing and drainage bags to be kept off the floor.</p> <p>3) Observations on the following dates and times of laundry carts being moved by Staff B, Laundry Aide:</p> <p>On 12/9/24 at 1:46 PM observed Staff B delivering resident laundry in an uncovered cart.</p> <p>On 12/10/24 at 11:35 AM observed Staff B transporting uncovered dirty clothes from the [NAME] Hallway across the serving area and outer dining area to the North Hallway.</p> <p>On 12/10/24 at 11:40 AM observed Staff B transporting an empty laundry cart from the North Hallway to the East Hallway. The staff picked up dirty clothes and moved the uncovered laundry cart from the East Hallway to the North Hallway.</p> <p>On 12/10/24 at 1:41 PM observed Staff B transport uncovered clean linens and slings from the North Hallway to the [NAME] and East Hallways.</p> <p>On 12/10/24 at 1:55 PM Staff B stated she should cover the laundry cart when delivering laundry. The staff stated they had forgotten to cover the laundry as there was too much going on, and that she typically covers it. Staff B further stated she was unaware that dirty laundry needed to be covered prior to transporting through the facility.</p> <p>The facility provided document, Handling of Clean Linen and Linen Distribution, revealed that clean laundry should be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. The document further revealed the cart should be covered once it is filled and distributed to the units.</p> <p>On 12/12/24 at 8:15 AM the IP/DON stated laundry should be covered at all times when transported in the facility.</p> <p>On 12/12/24 at 8:00 AM the Administrator stated it was the expectation that laundry be covered during transportation whether clean or dirty.</p>