STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165585	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Muscatine	2002 Cedar Street Muscatine, IA 52761

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45775 Based on clinical record review, facility policy review, hospice provider interviews, and staff interviews the facility failed to obtain Physician Orders for admission, diet. medications, and resident care for 1 of 3 residents reviewed for admissions (Resident #7). The facility reported a census of 33 residents. Findings Include: Per the facilities Admission/Discharge report, Resident #7 admitted to the facility on two separate occasions for respite services: a. admitted on [DATE], and discharged on [DATE] b. admitted on [DATE], and discharged on [DATE]. On 9/30/24 a review of Physician Orders revealed an order for carbidopa-levodopa extended release tablet 50-200 mg (milligrams), give 1.5 tablet by mouth two times a day for Parkinson's disease. The review of the electronic health record (EHR) and paper charts revealed a lacked Physician Orders for: admission, diet, additional medications, code status, and routine care. Also lacking from the record were contact information for a provider, assessments related to current health status, fall risk, elopement risk, and name and contact for hospice provider. The clinical record did include a hand-written note from the Resident #7 family. The note outlined the residents daily schedule, name of provider and the statement no food allergies. An informational sheet, typed and signed by the Administrator, provided staff with the following information: a. [Resident Name} - Respite Care Only This weekend b. September 20-September 22, 2024 1. Check in Friday Night at 6:00 PM (continued on next page)

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: 165585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Muscatine		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 Cedar Street Muscatine, IA 52761	

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Check out Sunday Afternoon around 4:00 PM c. Diet: Regular. He is to eat in the main dining room Saturday breakfast Lunch and Dinner. and Sunday Breakfast and Lunch. Family will be back before Supper. d. Activity Level: Ambulatory needs minimal assistance. Wears Depends at night please check on him. Family is bringing an overnight bag with his own depends, and changes of clothes and his own disposable bed pads. e. He does sometimes wonder in the night f. Family will shower him tonight here. e. Medication: Carb/levo ER ,d+[DATE] mg ER 1.5 tablets before breakfast and 1 and 1/2 tab supper. Medication will be in original bottle at Nurse Station f. DX (diagnosis): Parkinson's, Early Memory Loss e. Emergency Contacts: 1. [Name Redacted, phone number redacted] 2. [Name Redacted, phone number redacted] f. [Name redacted] was a [profession redacted] and likes to draw and work on things. He has some memory loss and likes to interact w/(with) people. Also like westerns on TV. [Name reacted] is trying a stay here for this weekend lets roll out the red carpet to see how he does. A Health Status Note dated 9/21/24 at 3:52 p.m., transcribed by Staff G, Licensed Practical Nurse (LPN) documented, Resident started out in a good mood this morning, received in report that he was up for the majority of the night. slept for about an hour this morning and was up. Resident walked the halls and then started to try and get into the med carts and the nurse's desk. Redirected to bed room. Right before lunch resident tried to go out the front door. Staff was able to catch resident before he got outside. Resident then continued to pace the hallways trying to get into other residents' rooms. During lunch resident did not want to take his medication, he was also picking up the plates of other resident and trying to eat the food off their plates. Family called to check on resident and this nurse asked if he was on any other medications before he came. Family stated that resident go out the front door and try to go to the mailbox. Asked if the resident was on any medications at home for anxiety, they stated that resident is on hospice and that he was on Xanax and lorazepam (antianxiety medications), but felt like it made him angry. Discussed getting a hold of hospice to see what they thought would help with his anxiety. An Incident Note dated 9/28/24 at 12:38 p.m., transcribed by Staff I, Registered Nurse documented, Resident in dining room after meal, attempting to pick up plates off of the table to clean up after himself and fell . Resident fell forward out of his wheelchair on to the right hip. Vitals obtained. B/P 117/81 P 89 T 98.0 R19 O2 96. Head to toe completed. Right hip area slightly reddened from fall. No injuries noted. Family informed. Doctor informed. Administrator informed. PRN (as needed) morphine administered per resident's request. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Aspire of Muscatine		STREET ADDRESS, CITY, STATE, ZIP CODE: 2002 Cedar Street Muscatine, IA 52761	

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Discharge Summary note note dated 9/29/24 at 5:56 p.m., transcribed by Staff I, RN documented, Resident picked up by family after weekend stay. No concerns at this time. Resident home with family. During an interview on 10/2/24 at 3:48 p.m., Staff F, RN, stated she worked the 6:00 p.m. to 6:00 a.m. shift starting on 9/20/24, and the resident was already at the facility when she arrived for her shift. Staff F stated the resident was not listed in the computer, the off-going nurse Staff B, RN instructed her that she didn't have to do anything for him because he wasn't listed as a resident, Staff F didn't think that sounded correct but Staff B had been in management there in the past so she didn't pursue the matter. The next morning when she gave report to Staff G, LPN, Staff G said that wasn't right, he had to be listed in the computer, they needed orders, and Staff G said she would take care of it. During an interview on 10/2/24 at 1:05 p.m., Staff H, LPN, stated the resident had a bottle of Roxonal (brand name of morphine, an opioid) kept in the narcotic compartment of the medication cart when he was there, and she recorded the dose that she administered to him on the facility's pink narcotic inventory sheet. During an interview 10/1/24 at 1:13 p.m., Staff N, sister facility Administrator stated there should have been physician orders for the resident's admissions and discharges, and orders that directed his care that would have included his code status while at the facility, and staff should have handled it as any other admission, with all the required assessments. During an interview on 10/3/24 at 9:56 a.m., the Administrator stated the resident's family toured the facility and wanted Respite care for him on the weekends, possibly placement, he notified the DON of the admissions on 9/18/24, and it would have been up to the DON to get the orders and direct the nursing staff with appropriate care and requirements for his admission. During an interview on 10/2/24 at 4:21 p.m., Staff A, DON at the time of the resident's admissions, stated the Administrator coordinated the resident's admissions, she didn't have anything to do with it, and thought the Administrator spoke to the resident's Hospice about it. During an interview on 10/2/24 at 1:46 p.m., Staff L, current facility DON, stated staff should have had physician orders that directed the resident's admission and care while at the facility, including medication administration, and staff should follow physician orders unless there is a contraindication, and they should obtain clarification from the physician if so. During an interview on 10/2/24 at 9:29 a.m., the Nursing Coordinator for the resident's hospice provider stated they were unaware of the resident's 9/20/24 admission to the facility until his nursing visit by their staff on 9/26/24. Their staff communicated with the resident's family about the provisions of their program and that Respite care at a nursing home should have been coordinated by his hospice provider. The staff was unaware the resident was at the facility again from 9/27/24 to 9/29/24. A facility policy, dated 3/2026, titled Admission & Discharge Process directed Admission to the facility is completed based on the facility's ability to provide care and services as directed by the attending physician's orders. The pollicy inl the following Procedure: 1. Review the resident care needs and physician orders. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Muscatine	2002 Cedar Street Muscatine, IA 52761

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Notify the referring agency of admission determination. 3. Determine bed placement based on clinical needs. 4. Obtain equipment and supplies as needed. The facility's undated Respite Care in Nursing Facility policy directed Resident are admitted into Respite care for a short term basis to relieve caregivers of care management duties. The policy included the following Procedure: a. Admission of resident with Physician orders for medications/treatments b. Baseline care plan for Activities of Daily Living c. Face sheet with resident demographics/emergency contact information d. Consent to Treat Completed e. Quick ADT (Admit/Discharge/Transfer) for short term admission

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26529 Based on clinical record review, resident family interviews and staff interviews the facility failed to properly implement the application and maintenance of a wound VAC (vacuum-assisted closure) wound drainage system for 1 of 1 resident's reviewed with surgical wounds (Resident #6). The facility reported a census of 33 residents. Findings include: A review of the facility document, titled Admission Notification, indicated Resident #6 admitted from local hospital. admitted not indicated. Primary DX (diagnosis) of cholelithiasis (gallstones). Equipment Needed: Wound Vac. Note Regarding Special Equipment - wound vac: to midline incision. ELOS (Expected Length of Stay); Short Term DC (discharge) Disposition (place): SNF (Skilled Nursing Facility) to home. A hospital discharge document, dated 9/12/24 revealed Resident #6 procedure history: colostomy in 2001, cholecystectomy (removal of gallbladder) on 9/3/24, and exploratory laparotomy on 9/4/24 for suspected wound infection. The hospital discharge document included the following wound care instructions, in-part: a. ABD (abdominal) -cleanse with saline, non-contact layer over exposed suture, black foam to wound bed, (wound VAC) pressure @125mm/hg (millimeters of mercury, the measurement used for pressure), low intensity, change 2-3x weekly & prn (as needed). b. L (left) JP drain (Jackson Pratt drain - a tube inserted under the skin during surgery to allow fluid to drain into a collection reservoir outside of the body) - cleanse with saline, cover staples with single layer of xeroform & silicone dressing, change with VAC dressing & prn. c. R (right) JP drain - cleanse with saline, cover staples with single layer of xeroform & silicone dressing, change with VAC dressing & prn. The hospital discharge orders also included: May use Tylenol of Advil as written on bottle for mild pain. A clinical record review on 9/17/24 revealed a lack of documentation of the resident's admission to the facility on [DATE], or the care the resident received while at the facility A Nursing Progress Note transcribed by Staff H, Licensed Practical Nurse (LPN) on 9/13/24 at 7:04 a.m. stated: Arrived for shift, no mention of resident in the facility during report from the night shift nurse. Certified Medication Aide's (CMA's) mentioned there was a new admission. Resident's room found empty, bed untouched, no belongings in room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/24 at 9:40 AM, Staff A, Interim Director of Nursing (DON) stated she admitted Resident #6 to the facility. The DON stated she is unsure of the date, but it was around lunch time. The DON stated she worked the floor that day as the nurse. She explained the resident had a long abdominal incision, and two stab-wound punctures, on either side of the incision, from the previous JP drain sites. The DON stated the resident also had a colostomy appliance making the application of the wound VAC difficult. She stated after the equipment [wound VAC and supplies] arrived, she attempted to put apply the wound VAC. She estimated this was around 2:00 p.m. The [NAME] stated the wound Vac worked for a while, then it was not working. She stated Staff B, RN relieved her for the 2:00 p.m. shift. She stated they both tried to reapply the wound VAC and could not get the drainage system to seal (a wound Vac will not provide the necessary suction if the dressing and connected collection system is not sealed). Staff A stated she couldn't enter a Nursing Progress Note related to the resident's admission or the care she provided because the resident was not listed in the computer software program as a current resident at the time of the care she provided. Staff A stated she received a phone call from Staff B around 5:30 p.m., to inform her the resident's family was not happy that the wound Vac was not working and they called an ambulance for the resident, she [Resident #6] was admitted to the hospital at that time. During an interview on 9/19/24 at 6:51 p.m., Staff B, Registered Nurse (RN) stated on 9/12/24 the facility called her in to relieve the DON from 2:00 p.m. to 6:00 p.m. She stated the DON had been the only nurse on duty. Staff B stated the DON informed her Resident #6 wound VAC was not working. She stated she examined the resident with the DON at between 2:45 p.m. and 3:00 p.m Staff B stated the reason the wound VAC was not working was because the DON incorrectly applied the adhesive dressing over the top of the colostomy bag. She stated all of the adhesive dressings applied to the resident's abdomen needed to be removed and reapplied, the resident had visible signs of pain and the resident stated she was in pain at the time. Staff B stated her first thought was to administer pain medication to the resident, allow the medication to work and then change the dressing, but she could not find the written physician orders for the resident and notified medical records staff (Staff M) that she needed the orders. Staff B stated the resident's family members arrived and were upset because the wound VAC was not working and the resident was in pain. Staff B stated she had other care priorities at the same time and had been unable to see the physician orders for Resident #6, that would have included pain management medication. Staff B stated around 4:30 p.m. the family asked if they should take the resident back to the hospital so she could get the care needed, they called an ambulance, the resident left in the ambulance around 5:00 p.m. and was admitted to the hospital. Staff B stated she was unable to document the care of the resident because the resident was not a current resident in the computer system. During an interview on 9/19/24 at 1:39 p.m., Staff E, RN, Nurse Case Manager from the referring hospital stated the resident left the hospital at 10:30 a.m. on 9/12/24, transported in a wheelchair van to the facility. She stated all physician orders were faxed to both an Admission Coordinator for the facility's corporation, and to a fax number at the facility on 9/12/24 at 9:13 a.m. per her records. The resident had a wound VAC while at the hospital, however the device had been removed by hospital staff prior to the 10:30 a.m. discharge/transfer to the facility. The wound VAC removed as property of the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/24 at 10:09 a.m., a family member stated they arrived at the facility at approximately 4:00 p.m. on 9/12/24, another family member was already there. Both family members were very concerned because the resident was in pain, staff stated they [the facility] did not have physician orders to administer pain medication and would have to obtain the orders, and the wound VAC was not working, there was no suction to the wound area. When they addressed their concerns with the nurse on duty, the nurse had other resident's that also needed care at the same time and couldn't tell them when she would have pain medication for the resident or when she would be able to fix the wound VAC dressing, and they decided to take the resident back to the hospital where she would get the care she needed. A Health Status Note transcribed 9/19/24 at 8:42 a.m., recorded as a Late Entry by Staff A, Interim DON [position listed on note MDS Coordinator]: a. At 9/12/24 12:00 p.m. Resident arrived via transportation services in wheelchair. Resident brought to room and assisted into bed, 4+ pitting edema (severe swelling with fluid retention, when pressure applied to the area with a finger the indentation in the skin made by the finger does not return to normal after 60 seconds) noted to bilateral lower extremities, resident reports edema worsened since left hospital, bilateral lower extremities elevated on pillows in bed, lungs clear to auscultation, heart rate regular, denies pain, reports exhaustion from trip, orientated to room, lunch tray provided. Wet to dry dressing intact, Wound Vac supplies being delivered today, colostomy intact, vital signs stable, T 98.0, P 72, R 16, BP 124/78, O2 97% on room air, abdomen distended, bowel sounds active, dressing to previous Jackson Pratt drain sites intact, up with assist of one and walker, therapy to eval and treat, resident requested to sleep before any treatments or therapies due to the long ride wearing her out, orders faxed. b. At 9/12/24 2:00 p.m. Wound Vac supplies arrived, therapy working with resident will come back once done. c. At 9/12/24 2:30 p.m. Wound Vac and supplies delivered and applied to resident, no leaks noted, Wound Vac patent. d. At 9/12/24 3:00 p.m. Wound Vac dressing leaking, dressing reinforced without success then removed and new dressing applied without success, multiple attempts by multiple nurses made to apply Wound Vac, colostomy and Jackson Pratt dressings interfering with suction, plan for Staff B, RN to remove all dressings and colostomy bag and reapply all starting with Wound Vac dressing.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 26529 Based on clinical record review, and staff and resident family interviews, the facility failed to have competent nursing staff to apply and manage a wound VAC (vacuum - assisted closure) wound drainage system, a device commonly used after complicated surgical procedures, for 1 of 1 resident's reviewed with surgical wounds (Resident #6). The facility reported a census of 33 residents. Findings include: A review of the facility document, titled Admission Notification, revealed Resident #6 admitted from a local hospital for short term staff for skilled nursing care with the goal of returning home. The date on the Admission Notification was not indicated. The document revealed the Equipment Needed: Wound Vac, with Note Regarding Equipment - wound vac: to midline incision. A hospital discharge document, dated 9/12/24 documented Admit to Skilled Nursing/Long Term Care Facility. The discharge document included wound care instructions, in part: Abdominal Wound: Cleanse with normal saline, place non-contact layer over exposed sutures, black foam to wound bed, and apply Wound Vac with pressure at 125 mm/hg, (millimeters of mercury, the measurement used for pressure) low intensity, change Monday, Wednesday, Friday, and PRN (as needed). During an interview on 9/18/24 at 9:40 a.m., Staff A, Interim Director of Nursing (DON) Director of Nursing (DON) stated she worked the floor the day of Resident #6's admission. The DON stated she tried to put the wound VAC on the resident. She explained the resident had long abdominal incision, with two stab-wound punctures from the previous JP drain sites, one on each side of the incision. The DON stated the resident also had a colostomy appliance (opening in abdominal wall to divert colon contents to outside of the body into a collection bag). The DON stated this made the wound VAC application difficult. She estimated she applied the Wound Vac around 2:00 p.m., it worked for a while, then it wasn't working. Staff A stated she was relieved by Staff B, RN and they attempted to reapply the wound VAC but were unsuccessful. During an interview on 9/19/24 at 6:51 p.m., Staff B, RN, stated relieved the DON on 9/12/24. Staff B stated the DON informed her Resident #6 had a wound VAC and it was not working. She stated she examined the resident with the DON between 2:45 p.m. and 3:00 p.m Staff B stated the reason the wound VAC was not working was because the DON applied the adhesive dressing over the top of the resident's colostomy bag, which is not a correct application for the device. She stated the adhesive dressings applied to the resident's abdomen would have to be removed and then correctly applied. Staff B stated the DON attempted to add additional adhesive dressing on top of the dressing to obtain a seal, but that did not work. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/19/24 at 8:31 a.m., Staff D, Certified Nursing Assistant (CNA) stated on 9/12/24 at approximately 4:05 p.m., the resident's call light was on, she entered the room, family members were present and said the wound VAC machine was not working. Her family member had pulled up her gown to show her stomach area, and Staff D saw that the wound VAC dressing had been applied over the top of the resident's colostomy bag, that was a problem for both the wound VAC machine, and she wasn't sure how she could empty the colostomy bag when needed. Staff D went to get the nurse, Staff B, she was aware it wasn't working and said she was waiting for orders from the doctor. During an interview on 9/17/24 at 10:09 a.m., a family member stated they arrived at the facility at approximately 4:00 p.m. on 9/12/24. The family member stated they and another family member present were very concerned because the resident was in pain and the wound VAC was not working. They explained the dressing had been applied over the colostomy bag which was incorrect, and there was no suction to the wound area because of the incorrect dressing application When they addressed their concerns with the nurse on duty, Staff B, RN. The family member stated Staff B states she was aware the wound VAC was not working and did not know when she would be able to apply the dressing correctly due to other responsibilities she had at the same time. The family called for an ambulance at 4:50 p.m. so the resident could go back to the hospital where she would get the care she needed. The family member stated they had observed hospital nursing staff apply the Wound Vac dressing to the resident, they didn't put it over the colostomy bag, it was applied to her skin and covered the long incision. A Health Status Note transcribed 9/19/24 at 8:42 a.m., recorded as a Late Entry by Staff A, DON documented: 9/12/24 12:00 p.m., Resident arrived via transportation services in wheelchair. Resident brought to room and assisted into bed, 4+ pitting edema (severe swelling with fluid retention, when pressure applied to the area with a finger the indentation in the skin made by the finger does not return to normal after 60 seconds) noted to bilateral lower extremities, resident reports edema worsened since left hospital, bilateral lower extremities elevated on pillows in bed, lungs clear to auscultation, heart rate regular, denies pain, reports exhaustion from trip, orientated to room, lunch tray provided. Wet to dry dressing intact, Wound Vac supplies being delivered today, colostomy intact, vital signs stable, T 98.0, P 72, R 16, BP 124/78, O2 97% on room air, abdomen distended, bowel sounds active, dressing to previous Jackson Pratt drain sites intact, up with assist of one and walker, therapy to eval and treat, resident requested to sleep before any treatments or therapies due to the long ride wearing her out, orders faxed. 9/12/24 2:00 p.m., Wound Vac supplies arrived, therapy working with resident will come back once done. 9/12/24 2:30 p.m., Wound Vac and supplies delivered and applied to resident, no leaks noted, Wound Vac patent. 9/12/24 3:00 p.m., Wound Vac dressing leaking, dressing reinforced without success then removed and new dressing applied without success, multiple attempts by multiple nurses made to apply Wound Vac, colostomy and Jackson Pratt dressings interfering with suction, plan for Staff B, RN to remove all dressings and colostomy bag and reapply all starting with Wound Vac dressing.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26529 Based on clinical record review, facility policy review, hospice provider interviews, and staff interviews, the facility failed to identify a new admission for respite services received established in-home hospice services and to coordinate the services with the already contracted hospice provider for 1 of 2 residents (Resident #7) reviewed for hospice services. The facility reported a census of 33 residents. Findings include: The facility's Admission/Discharge listing report, dated 9/30/24, revealed Resident #7 to the facility on two separate occasions. a. admitted on [DATE], discharged on [DATE]. b. admitted on [DATE], discharged on [DATE]. A clinical record review on 9/30/24 revealed a lack of: physician orders for admission, medical history, and name and contact number for hospice provider. The record review revealed two sources of information regarding Resident #7: a. A handwritten note provided by the family outlined a daily schedule, with the name of the primary provider and the statement no food allergies b. An informational sheet, typed and signed by the Administrator, provided staff with the following information: 1. [Resident Name} - Respite Care Only This weekend 2. September 20-September 22, 2024 - Check in Friday Night at 6:00 PM; Check out Sunday Afternoon around 4:00 PM 3. Diet: Regular. He is to eat in the main dining room Saturday breakfast Lunch and Dinner. and Sunday Breakfast and Lunch. Family will be back before Supper. 4. Activity Level: Ambulatory needs minimal assistance. Wears Depends at night please check on him. Family is bringing an overnight bag with his own depends, and changes of clothes and his own disposable bed pads. 5. He does sometimes wonder in the night 6. Family will shower him tonight here. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Aspire of Muscatine		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 Cedar Street Muscatine, IA 52761	

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Medication: Carb/levo ER ,d+[DATE] mg ER 1.5 tablets before breakfast and 1 and 1/2 tab supper. Medication will be in original bottle at Nurse Station 8. DX (diagnosis): Parkinson's, Early Memory Loss 9. Emergency Contacts: a. [Name Redacted, phone number redacted] b. [Name Redacted, phone number redacted] 10. [Name redacted] was a [profession redacted] and likes to draw and work on things. He has some memory loss and likes to interact w/(with) people. Also like westerns on TV. [Name reacted] is trying a stay here for this weekend lets roll out the red carpet to see how he does. Neither the handwritten note or the information sheet identified Resident #7 received hospice services. A Health Status Note, dated 9/21/24 at 3:52 p.m., transcribed by Staff G, Licensed Practical Nurse (LPN) revealed, in part .Family called to check on resident and this nurse asked if he was on any other medications before he came. Family stated that resident go out the front door and try to go to the mailbox. Asked if the resident was on any medications at home for anxiety, they stated that resident is on hospice and that he was on Xanax and lorazepam (anti-anxiety medications), but felt like it made him angry. Discussed getting a hold of hospice to see what they thought would help with his anxiety. During an interview on 10/2/24 at 3:48 p.m., Staff F, Registered Nurse (RN), stated she worked the 6:00 p.m. to 6:00 a.m. shift starting on 9/20/24, and the resident was already at the facility when she arrived for her shift. Staff F stated the resident was not listed in the computer, the off-going nurse Staff B, RN instructed her that she didn't have to do anything for him because he wasn't listed as a resident, Staff F didn't think that sounded correct but Staff B had been in management there in the past so she didn't pursue the matter. Staff F stated she gave report to the oncoming nurse, Staff G, LPN the next morning. She stated Staff G informed her that it wasn't right, the resident had to be listed in the computer, they needed orders. Staff F stated she was called into work after 6:00 p.m. on 9/27/24. Resident #7 was at the facility for a second Respite stay. Staff F stated she called the DON (Director of Nursing) because as before, the resident wasn't in the computer and there were no physician orders for him. Staff F reported the DON stated he was there for Respite so she didn't have to admit him, and his hospice would have his orders if she did need something. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Aspire of Muscatine		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 Cedar Street Muscatine, IA 52761	

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/24 at 12:06 p.m., Staff G, LPN, stated she worked the 6 a.m. to 6 p.m. shift on 9/21/24, the resident had arrived at the facility the evening before, he wasn't listed in the computer and there were no physician orders for him in the computer. She stated she called the DON to ask why the resident was not in the computer and the DON told her that it would have been up to the Admission Coordinator, or the Administrator to put the resident in the computer. Staff G stated the DON didn't provide much assistance over the phone, it was a weekend and Staff G did what she could, but they needed physician orders, the resident's history and medication list, things you normally have with an admission, and they didn't have that. During an interview on 10/2/24 at 4:21 p.m., Staff A, DON, stated the Administrator coordinated the resident's admissions, she didn't have anything to do with it, and thought the Administrator spoke to the resident's hospice about the admission. During an interview on 10/3/24 at 9:56 a.m., the Administrator stated the resident's family toured the facility and wanted Respite care for him on the weekends, possibly placement, he notified the DON of the admissions on 9/18/24, and it would have been up to the DON to get the orders and direct the nursing staff with appropriate care and requirements for his admission, and it would have been up to the DON to communicate with the resident's hospice for coordination. During an interview on 10/2/24 at 9:29 a.m., the Nursing Coordinator for the resident's hospice provider stated they were unaware of the resident's 9/20/24 admission to the facility until his nursing visit at his home by their staff on 9/26/24. Their staff communicated with the resident's family about the provisions of their program and that Respite care at a nursing home should have been coordinated by his hospice provider. The staff was unaware the resident was admitted to the facility again from 9/27/24 to 9/29/24. When they refer their hospice residents to nursing homes for Respite care, there are strict protocols to follow for physician orders, coordination of care and reimbursement for services, and facility staff have to communicate with hospice staff about the resident's care. They had not received any communication from facility staff about either of the resident's admissions to their facility, his family member was who told his nurse that he had been at the nursing home over the weekend. The Nursing Coordinator stated their hospice staff always visit the nursing home prior to the resident's placement for Respite care, to ensure the facility would be able to meet the care needs of the resident, and they always visit the resident within 4 hours of admission to the facility to make sure everything was going as planned, or to address any needs. The resident lived an hour from the facility and it was not the facility that they would have placed the resident at for Respite care due to the distance from his home. A facility policy, dated 3/2026, titled Admission & Discharge Process directed Admission to the facility is completed based on the facility's ability to provide care and services as directed by the attending physician's orders. The policy included the following Procedure: 1. Review the resident care needs and physician orders. 2. Notify the referring agency of admission determination. 3. Determine bed placement based on clinical needs. 4. Obtain equipment and supplies as needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Muscatine	2002 Cedar Street Muscatine, IA 52761

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Respite Care in Nursing Facility policy directed Resident are admitted into Respite care for a short-term basis to relieve caregivers of care management duties. The policy included the following Procedure: a. Admission of resident with Physician orders for medications/treatments b. Baseline care plan for Activities of Daily Living c. Face sheet with resident demographics/emergency contact information d. Consent to Treat Completed e. Quick ADT (Admit/Discharge/Transfer) for short term admission Neither policy addressed the need to identify if resident has established hospice services and the need to coordinate services.