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	01/28/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, facilty policy, resident and staff interviews, the facility failed to ensure residents are treated in a dignified manner as evidenced by a staff members use of an expletive when requesting a resident move their belongings for 1 of 7 residents reviewed for dignity (Resident #1). The facility reported a census of 35 residents. Findings include: The Minimum Data Set (MDS) assessment completed for Resident #1 on 12/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. During an interview on 1/6/25 at 10:29 a.m., Resident #1 stated she had an issue with the activity lady. She stated she had a blue flowered [NAME] and the activity lady said she would help Resident #1 finish it and when she came in with it the activity lady told her You need to get that f***ing thing off my table. Resident #1 stated she said whoa, I didn't disrespect you and you told me to go and get my [NAME]. Resident #1 said the activity lady was the one with the glue gun. Resident #1 stated she told the nurse and they did a report on it. Resident #1 asked what the activity personnel did after the encounter and she said the activity lady walked out of the room and took her [NAME] back to her room and that was the end of it. The Grievance Form dated 12/23/24 for Resident #1 and reported by [name redacted] revealed the following: a. Who made the report: Patient b. Nature of Grievance: I had left a project on the table in the activity room and went to my room to get something for it and [name redacted] to me to get my f**king shit off her table but she took it upon her self to take it back in my room and I was not happy about it made me cry, my family don't even talk to me like that and I don't except no one else to talk to me like that. c. Signed by Resident #1 on 12/22/24 and the Admin signed on 12/26/24 (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: 165585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Aspire of Muscatine		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 Cedar Street Muscatine, IA 52761	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/6/25 at 1:15 p.m., Staff E, Activities Director queried on any complaints against her from residents stated she had one complaint from a resident. She stated the resident took it the wrong way. Staff E explained she said something about getting her f**king things off my table. Staff E stated while making Christmas wreaths, the resident had a different [NAME] and had it sitting on the table. Staff E stated she moved the [NAME], and the resident brought the same [NAME] back to the table. She stated she made the remark in a sarcastic kind of way, not a rude way. Staff E stated in the grievance the resident stated she was upset. Staff E stated she didn't mean to hurt her feelings and that day she stayed in the activity area. She stated the resident took the remark the wrong way. Staff E stated she messed up and sometimes you had connections with people. She stated she never directly cussed at anyone. Staff E stated she didn't know she offended the resident until the grievance form and Social Services spoke to her and informed her she couldn't speak to the residents in that matter even if it was in a joking matter. During an interview on 1/7/25 at 12:46 p.m., Staff F, Social Services queried on Resident #1 and she stated she recalled a grievance that Resident #1 wrote. Staff F stated grievances usually went to her, but this grievance went to the DON (Director of Nursing) and the DON brought it to her office and they discussed it. Staff F confirmed the grievance named Staff E and documented Staff E said something to the effect of get your s**t off my table or along those lines. Staff F stated the grievances documented inappropriate language. Staff F asked if they investigated it and she stated yes, they started talking with Resident #1 and then spoke to Staff E. Staff F stated education completed with Staff E about language like that in the workplace was not appropriate. Staff F asked this situation reported and she stated the Administrator notified of it and she believed they reported it to our office, but wasn't completed sure. During an interview on 1/8/25 at 11:40 a.m., Staff E confirmed Resident #1 submitted a grievance on her for swearing at her to get things off her desk. During an interview on 1/8/25 at 2:48 p.m., Resident #1 queried on the incident between her and Staff E and how that made her feel and she stated Not to good, I wanted to run my mouth back, but I didn't know how they would take it if I responded back the way I wanted to. Resident #1 asked if it made her feel fearful or intimated and she stated she felt intimated, and she didn't know how you could talk to someone like that. Resident #1 queried if she minded being around Staff F and she stated it would take a little time to get that back. Resident #1 asked if she went to the activity room much and she stated she didn't see Staff E much lately and didn't know if she had time off. During an interview on 1/9/25 at 10:35 a.m., the DON (Director of Nursing) queried on the incident between Resident #1 and Staff E and she stated she thought they were making a mountain out of a mole hill. The DON stated the situation should of never happened in healthcare. The DON stated she spoke to Resident #1 and she stated she didn't like being talked to like that and no one talked to her like that, not even her family. The DON stated Resident #1 was fine with it, just not Staff E tone. The DON stated she believed Staff E intentions are pure. The DON stated she watched Resident #1 and Staff E for a few days and she thought Staff E misinterpreted the relationship and in her mind it wasn't a bad thing. The DON stated she spoke with Staff E and they 100% addressed the situation. The DON stated she believed the Administrator did the investigation. The DON stated potty mouths don't belong in healthcare. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 12:12 p.m., the Administrator queried on the incident between Resident #1 and Staff E and she stated it started out as a grievance. The Administrator stated she wondered if the incident happened because Resident #1 was pretty truthful. The Administrator stated the DON talked to her the next day and then she talked to Resident #1 as well. The Administrator stated Resident #1 was more concerned with Staff E tone and Resident #1 was not afraid of Staff E and Resident #1 was heavily involved in activities. The Facility Resident's Rights Policy dated 12/24 revealed the following information: a. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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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** 26529 Based on clinical record review, facility policy review, resident and staff interviews, the facility failed to ensure residents are free from resident to resident (with Resident's #8, #9 and #17) altercations involving a resident (Resident #7) known to have difficulty managing his verbal and physical behavior. The facility reported a census of residents 35. Findings include: 1. A review of a facility self-reported incident report, dated 10/8/24, revealed on 10/7/24 while outside smoking, Resident's #7 accused Resident #8 of stealing his cigarettes. Resident #7 then threw his walker at Resident #8, hitting him on the right shoulder. Resident #7 hit Resident #8 on the right cheek with his fist. Resident #8 punched Resident #7 in the stomach. Resident #7 then yelled at Resident #9 calling her names and stating he was going to punch her lights out. Resident's #8 and #9 went inside the facility and went to a nurse. Resident #7 followed them into the building. The nurse separated Resident #8 and #9 from Resident #7. Resident #7 remained in the dining room and continued to yell profanities. Corrective Action per the facility self-report: The residents were separated by nursing staff, DON (Director of Nursing) and Social Services. Police were notified of the incident and came to the building. Resident #7 as sent by ambulance to [hospital name redacted] evaluated. Resident #8 had a skin assessment completed and trauma assessment completed. Resident #9 denied being hurt but a trauma assessment was being completed. The facility reported incident, identified: a. Resident #7 as Severely Impaired Cognition. No injuries. HX (history): [Name redacted] has a history of accusing staff and residents of stealing items from him. He also has a history of making physical violence threats. b. Resident # 9 as Alert and Oriented. No injuries. No HX per facility. c. Resident #8 as Alert and Oriented. No Injury. No HX per facility. The Minimum Data Set (MDS) Assessment for Resident #7, dated 9/2/24 revealed no cognitive assessment completed. Resident #7 identified as usually able to make himself understood, always understood others and without behaviors. The electronic health record Medical Diagnosis list for Resident #7, dated 12/23/24 included, in part: unspecified dementia, unspecified severity with behavioral disturbance as secondary diagnosis on 7/16/24, and violent behavior as secondary diagnosis on 7/16/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's Care Plan, initiated on 6/22/24 included a Focus area to address [Name redacted] is a risk for increased verbal and physical behaviors r/t (related to) increasing depression r/t being in facility, accuchecks (blood sugar checks) not in control and other health concerns. The Focus area included, in part: a. [Name redacted] has been involved in a res (resident) to res altercation. b. [Name redacted] hit and injured a staff member and was sent out via ambulance and police called on 7-15-24 c. 10/7/24 Resident hit and threatened residents and accusing them of stealing his cigarettes. d. 10-8-24 Resident was verbally aggressive towards other in the dining room. Date initiated: 6/22/24. e. [Name redacted] has had an altercation and was the recipient of physical aggression. Dated initiated: 10/7/24. Interventions included, in part: a. Referral to [provider name redacted] psychological/psychiatric services as first available appointment. Dated initiated: 6/22/24 b. Separate from others res for safety. Date Initiated: 6/22/24 c. 10-8-24 Referrals being sent to CCDI (Chronic Confusion and Dementing Illness) Units in Iowa that are more appropriate for his needs. Dated initiated: 10/8/24. During an interview on 12/23/24 at 9:08 a.m., the former Director of Nursing (DON) stated she was in the hallway near the dining room on 10/7/24 when Resident's #7, #8 and #9 were outside smoking, Resident #7 accused them of stealing his cigarettes. She stated that was a common thing he [Resident #7] believed but that was not true as staff secured the cigarettes. She stated Resident #7 punched Resident #8 on his shoulder and his head, Resident #8 hit Resident #7 in the stomach as Resident #7 threw his walker at him, and Resident #9 came back into the facility and yelled for help. The former DON stated she and another staff responded and were able to separate the residents. She stated Resident #7 was sent to the hospital for a psychiatric evaluation, and then returned. The former DON stated prior to that incident, the residents could smoke on the patio, unsupervised, whenever they wanted. Afterwards, the DON stated things were changed to three set times which the residents could smoke outside, staff provided supervision, resident's that smoked had to have a smoking safety assessment completed, and sign a consent for acceptance of the smoking rules and restrictions. The former DON stated they also made sure that Resident #7 was supervised 1:1 with staff and was not outside when other residents were outside smoking. The DON stated the Social Worker was responsible for completing the smoking safety assessments and getting the consents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/24 at 12:18p.m., Staff S, Registered Nurse (RN) stated Resident #7 can be a ticking timebomb, unpredictable and aggressive, not easily redirected when he's escalating. Staff S stated staff have to keep an eye on him, and be ready to separate him if he goes after another resident. She stated there is no redirecting him when he is that agitated, they try to guide him to his room to cool down and keep him away from other residents. During an interview on 12/31/24 at 12:47 p.m., Resident #8 stated when he smoked outside there was a day that Resident #7 yelled at him, accused him of stealing his cigarettes, hit him in the face and shoulder with his fist then threw his walker at him. Resident #8 stated he wasn't hurt when Resident #7 hit him because Resident #7 hits like a girl, and then laughed. Resident #8 stated the residents couldn't go outside to smoke on their own after that, there are set times for residents to smoke now and a staff member has to be present. The MDS, dated [DATE] revealed Resident #8 BIMS score of 15 out of 15 which indicated intact cognition. A Nursing Progress Note transcribed by Staff S, RN on 10/7/24 at 6:15 p.m. stated: Head-to-toe assessment performed. Slight redness noted to resident's [Resident #8] face. No further concerns at this time. During an interview on 1/7/24 at 11:39 a.m. Resident #9 stated Resident #7 yelled at her many times, called her horrible things and threw whatever he could get a hold of when he was agitated, there was no rhyme or reason when that would occur. The MDS, dated [DATE] revealed Resident #9 BIMS score as 15 out of 15 which indicated cognition intact. A Nursing Progress Note transcribed by the previous DON on 10/7/24 at 4:53 p.m. stated: Resident [Resident #9] was in courtyard when another resident came outside yelling and accusing them of stealing his cigarettes. He then started hitting another resident. He also waived his fist at this resident, called her a profane name and threatened her. She removed herself from the situation and asked the nurse for help with the other resident. 2. A review of a facility self-reported incident, dated 1/11/25 at 10:25 p.m., revealed Resident #7 and Resident #17 were in the dining room by the coffee station. [Staff name redacted], Licensed Practical Nurse (LPN) came around the corner from the nurse's station and saw Resident #7 grab Resident #17's shoulder, and called him a racial slur and hit him with a closed fist to the right side of his head. He [Resident #7] swung a couple of times but only connected one time. [Staff name redacted], LPN linked her arm in Resident #7's arm and redirected him back to his room. Corrective Action per the facility self-report: Residents immediately separated. Resident #7 was redirected to his room and a staff member remained in the line of sight of him. Resident #17 was assessed and sent to the ER for evaluation and treatment .Resident #7 was sent to the ER for evaluation and treatment. The facility self-report identified: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Resident #7 as Moderately Impaired Cognitively. No injury. HX: Yes, [resident name redacted] has had other resident to resident altercations within the last 3 months. b. Resident #17 as Alert and Oriented. Injury: Swelling to the right side of face. HX; No history of similar events. A review of a Nursing Progress Notes transcribed by Staff T, LPN on 1/12/24 at 8:40 a.m., revealed this nurse heard yelling while down the hall, ran to the common area and discovered [Name redacted (Resident #7)] physically grabbing another resident's shoulder. Resident [#7] yelled a yelled [racial slur] and close palm punched resident [Resident #17] on the right side of his head. This nurse and two CNA's separated the two residents . A review of the hospital Emergency Department Physician Progress Note dated 1/11/25 revealed Resident #7 arrived at 9:24 p.m., treated for aggressive behavior due to dementia after he hit another resident at the nursing home, the resident remained calm and cooperative in the Emergency Department, discharged back to the facility on [DATE] at 12:25 a.m. with a prescription for oral Lorazepam 0.5 milligrams (mg) tablets administered every 6 hours as needed for anxiety, 5 tablets dispensed, the resident received 1 dose while in the Emergency Department. During an interview on 1/21/25 at 2:10 p.m., Staff T, LPN, stated she worked the 6 p.m. to 6 a.m. night shift on 1/11/25. She stated during the evening she was on the South hall when she heard yelling at 8:40 p.m. and ran to the sound. Resident #7 stood near the kitchen door in the dining room, Resident #17 was in his wheelchair and was wheeling away, Resident #7 was hitting him with a closed fist on his head. She tried to get between them and escorted Resident #7 to his room. Resident #17 had a red mark on his right upper cheek. She called both the Administrator and DON after the incident, they wanted Resident #7 sent to the ER for a psychiatric assessment, called the police in case he escalated and remained with Resident #7 in his room until EMS got there to transport. The DON directed her to check him every 15 minutes, she didn't remember if it was for 24 or 48 hours. Resident #17 was also sent to the hospital ER for evaluation. Resident #7 came back from the ER early in the morning, they had medicated him in the ER, he was tired went to bed, he remained calm and asleep throughout the rest of her shift, she checked on him often. She notified the Administrator that he was back and she said they were supposed to keep him for 24 hours in the ER before they sent him back. She had not been directed to move Resident #17 to a different room, he remained in the same hall as Resident #7. When she came back to work the next day, they had moved Resident #17 to a different hall. 3. A review of a facility self-reported incident, dated 1/12/25 at 10:09 a.m., revealed Resident #17 sat in his wheelchair on hall 1, near the dining room. Resident #7 came out of his room, headed towards the dining room and came up behind Resident #17 wheelchair. When Resident #17 did not move right away Resident #7 raised his walker 6 inches off the ground and hit Resident #17 left arm with it. This nurse intervened as Resident #7 and Resident #17 were in line of sight as soon as Resident #7 left his room. Resident #17 went to his room. Resident #7 came out of the dining room as if nothing had occurred. Corrective Action per the facility self-report: Resident #7 was assessed, and his PRN (as needed) Haldol (antipsychotic medication) was administered. Administrator notified. Resident #7 is being kept in line of sight . Resident #7 being sent to ER for evaluation and treatment. The facility self-report identified: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Resident #7 with Moderately Impaired Cognition. No injury. HX: Yes, Resident #7 has had other resident to resident altercations within the last three months. b. Resident #17 as Alert and Oriented. No Injury. HX He has been involved in another resident to resident with this individual. A review of a Nursing Progress Note transcribed by Staff S, RN on 1/12/25 at 10:48 a.m., revealed: Med aide had stopped Resident #17 on hall one d/t (due to) resident going down the hallway backwards. Resident #17 was sitting on hall 1 in a wheelchair waiting on other resident to pass. Resident #7 walked up behind him with a walker. When Resident #17 did not move right away Resident #7 walked around to residents left side almost as if to pass him. When he was directly on the left side of Resident #17, Resident #7 raised the walker slightly and hit Resident #17 with it. This nurse intervened. Resident #17 went to his room. Resident #7 came out to the dining room as if nothing had occurred. PRN Haldol PO (by mouth) given to Resident #7. Administrator informed. DON informed. Medical Director informed. This nurse instructed by administrator to call police and have resident sent to ED (emergency department) for evaluation and treatment. When EMS arrived resident in room sleeping. Resident went willingly to ED. POA (power of attorney) and significant other informed. During an interview on 1/23/25 at 12:50 p.m., Staff S, RN, stated she worked the 6 a.m. to 6 p.m. day shift on 1/12/25. She was directed to provide 1 to 1 staffing with Resident #7 if possible, and if not, he was supposed to be in line of site of a staff member at all times. That morning he was in his room, initially asleep, then woke up around the time of the first resident smoking break. Staff O, CMA was standing at the Med cart, Resident #17 was in his wheelchair, he pushed himself backwards as he left the dining room going down the hall to his room. Staff O told him that he needed to turn around so he didn't run into someone and got him turned around. Resident #7 had been in his room up to that point, and Staff S was positioned at the Nurse's Station and could see if he came out of his room. He was coming out of his room as Resident #17 was in the hall, between the kitchen door and the set of fire doors area. Resident #7 walked with his walker towards the dining room, and it looked like he was going to go right past Resident #17 without incident, Staff S was ready to intervene if needed, and when he was right next to Resident #17 that's when he switched and he took his walker and tried to hit him with it. Staff S couldn't get there before that happened, got Resident #17 to go to his room and Resident #7 went to the dining room. She gave Resident #7 oral Haldol medication (antipsychotic) 2 milligrams, ordered oral every 4 hours as needed, notified the DON and the Administrator, the Administrator said to send him out, she got the orders and he went to the ER. He was back from the ER by 1 p.m. with no new orders. While Resident #7 was in the ER they moved Resident #17 back to his old room on the South hall. They kept Resident #7 within line of sight at all times upon his return. During an interview on 1/23/25 at 1:14 p.m., when asked about the recent incident with another resident that occurred near the dining room, Resident #7 stated that the other resident came up to him, rammed his (Resident #7's) walker into him, it didn't hurt, the other resident took off and Resident #7 kept doing what he was doing in the dining room. Resident #7 denied that he hit the other resident or had done anything to him, either then or at any other time. Resident #7 stated he had been upset 1 other time about a resident there, but doesn't remember which resident it was or what he was upset about. Resident #7 stated he felt safe at the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 1:22 p.m., when asked about the recent incidents with another resident that occurred near the dining room, Resident #17 stated that the other resident [Resident #7] was very unpredictable, out of nowhere that resident punched him and tried to hit him with his walker. During an interview on 1/23/25 at 1:38 p.m., Staff O, CNA, stated she had worked at the facility several years, she received dementia training at another facility several years ago, but had not had any behavior management training at the facility since she worked there. She learned the best approach with Resident #7 was to have 1 staff calmly respond to him verses several staff at the same time, and to gently try to guide him to his room to calm down in a quiet area. During an interview on 1/27/25 at 3:40 p.m., the Administrator stated she directed staff to send Resident #7 to the ER (emergency room) on 1/11/25. She stated they were supposed to hold him there for 24 hours, and she wasn't aware that he returned until she received a call from Staff S on the morning of 1/12/25 when he hit Resident #17 with his walker. She had directed staff to keep him in their line of sight at all times. The Administrator stated they didn't move Resident #17 on 1/11/25 because it was late, but staff moved to his old room in a different hall the next day [1/12/25]. The Administrator stated some of the resident's [Resident #7] agitation and aggression are because he wants to go home, the family want to have him at home, and they are exploring options to see if they can make that possible. A review of the facility policy, revised on 8/2024, titled Abuse Prevention Program revealed a Policy statement which declared: Residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, exploitation and involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical condition.

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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** 47336 Based on clinical record review, facility policy review, staff and resident interviews, the facility failed to report allegations of abuse for 2 of 5 residents reviewed for abuse (Resident #1 and Resident #6). The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 12/4/24 revealed Resident #1 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. During an interview on 1/6/25 at 10:29 a.m., Resident #1 stated she had an issue with the activity lady. She stated she had a blue flowered [NAME] and the activity lady said she would help Resident #1 finish it and when I came in with it the activity lady told her You need to get that [redacted expletive] thing off my table. Resident #1 stated she said whoa, I didn't disrespect you and you told me to go and get my [NAME]. Resident #1 said the activity lady was the one with the glue gun. Resident #1 stated she told the nurse and they did a report on it. Resident #1 asked what the activity personnel did after the encounter and she said the activity lady walked out of the room and took her [NAME] back to her room and that was the end of it. During an interview on 1/6/25 at 1:15 p.m., Staff E, Activities Director queried on any complaints against her from residents and she stated she had one complaint against her from a resident and the resident took it the wrong way. Staff E asked what she said to the resident and she stated she said something about getting her [redacted expletive] things off my table .Staff E stated she didn't know she offended the resident until the grievance form and Social Services spoke to her and informed her she couldn't speak to the residents in that matter even if it was in a joking matter. A review of a Grievance, dated 12/23/24 for Resident #1 and reported by [name redacted] revealed the following: a. Who made the report: Patient b. Nature of Grievance: I had left a project on the table in the activity room and went to my room to get something for it and [name redacted] to me to get my [expletive redacted]off her table but she took it upon herself to take it back in my room and I was not happy about it made me cry, my family don't even talk to me like that and I don't except no one else to talk to me like that. c. Signed by Resident #1 on 12/22/24, and Administrator signed on 12/26/24 During an interview on 1/9/25 at 12:12 p.m., the Administrator queried if she reported the incident with Resident #1 and Staff E as an allegation of abuse stated the allegation came in as a grievance and when she spoke with Resident #1 she was not afraid of Staff E and they handled the incident in house. The Administrator stated she saw it as a grievance, but now she understands no gray, just black and white and needs to report. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] revealed Resident #6 scored a 12 out of 15 on the BIMS exam, which indicated cognition moderately impaired. The MDS revealed medical diagnoses for anxiety and bipolar disorder. A review of an email, dated 12/13/24 at 2:20 p.m., from Staff I, MDS Coordinator to the facility Administrator revealed: I am sending this because I was just pull aside by 2 CNAs (Certified Nurse Aide) that informed me of something very disturbing. Both of them stated that Staff K, Maintenance Staff was in a res. (resident) room with [name redacted] and she stroked his beard and stated to the res. look his beard is very soft wouldn't you like to sit on it. I was floored and appalled, to top it off Staff K preceded to go to the nurse's station and tell the CNAs this and thought it was funny. Do something this is highly inappropriate. A review of an email, dated 12/16/24 at 11:28 a.m., from Staff A, Certified Nursing Assistant (CNA) to the facility Administrator revealed: On Wednesday December 11th, 2024 myself, [name redacted] the nurse, and [name redacted] the other CNA we at the station 1 nurses' desk when [name redacted] the maintenance guy approached the desk. I had started a discussion about a resident [initial redacted], because she had said how she had felt [name redacted] beard and it was really soft. [Name redacted] had laughed and said that he and [name redacted] (our social worker) had been in [initial redacted] room and that [name redacted] had said how [name redacted] beard was really soft she would feel it and she did saying that it was soft. He proceeded to laugh while telling us saying [name redacted] had then said I bet you'd like to sit on his face wouldn't you [initial redacted] and [name redacted] had told us that [name redacted] face had gotten bright red and didn't have anything to say about it. During an interview on 1/9/25 at 12:12 p.m., the Administrator queried if she reported the incident with Resident #1 stated the allegation came in as a grievance. She explained when she talked to Resident #1, Resident 1 stated she was not afraid of Staff E and they handled the incident in house. The Administrator queried on the incidents with Resident #6 stated she didn't know about the second incident with Resident #6. The Administrator stated she stated a staff member called her and said they was an allegation of abuse concerning Resident #1 and the Administrator asked for a written statement. The Administrator stated she didn't ask about the situation on the phone, wanted a written statement for it. The Administrator stated if the situation happened on the 11th, why did she not get notified until the 13th. The Administrator confirmed she did not report any of the incidents discussed to the office. A review of the facility policy, dated 10/2024, titled Reporting of Abuse Allegations included a Policy statement which declared: All suspected violations and all substantiated sources and misappropriate will be immediately reported to the appropriate state agencies and other entities or individuals as may be required by law.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on observations, clinical record review, facility policy review and staff interviews, the facility failed to use the appropriate slings size for 2 of 3 residents observed during transfers (Resident #2 and Resident #4); and failed to complete regular assessments for resident safety related to smoking for 3 of 3 residents (Resident's #7, #8 and #9). The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 scored a 9 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. The MDS revealed the resident had impairment on both sides of her lower extremities; used a walker and a wheelchair; and needed partial/moderate assistance with transfers from chair/bed to chair. The MDS listed diagnoses included: chronic obstructive pulmonary disease (COPD), unspecified and heart failure. The MDS Medication section identified Resident #2 took an anticoagulant. The Care Plan, date initiated 9/1/24 included a Focus area to address [Name redacted] requires assistance with ADL's (activities of daily living) r/t (related to) activity intolerance, limited physical mobility, and is at risk for self-care deficit. Interventions included, in part, Transfer: [Name reacted] requires 1 staff to move between surfaces as necessary. Uses walker and wheelchair transfer and mobility through the facility, dated initiated 9/1/24. A review of Physician Orders revealed an order for Eliquis (name brand of an anticoagulant) oral tablet 2.5 mg (milligrams), give 1 tablet by mouth two times a day for anticoagulant therapy. A review the Weight Summary, dated 1/7/25 revealed Resident #2 weighed 422.8 Lbs. (pounds) on 1/3/24 at 8:57 a.m. During an interview on 1/6/25 at 12:33 p.m., Resident #2 stated she couldn't walk right now but she wanted to go home. She stated she currently didn't do physical therapy because she was placed in hospice services. The Care Plan did not address the residents change in mobility, or associated interventions. During an observation on 1/6/25 at 12:33 p.m., Resident #2 sat in a Broda (a specific brand of chairs or wheelchairs used for comfort and positioning) in the dining room. Resident #2 had a mechanical lift sling under her in the wheelchair. The sling had green [NAME] with a royal blue center. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/6/25 at 2:45 p.m., Staff A, CNA (Certified Nursing Assistant) and Staff B, CNA transferred the resident from the Broda chair to the bed using a mechanical lift. Prior to the transfer, Staff A informed Staff B that day shift used too small of a sling for the resident today. The sling had green [NAME] and a royal blue center. She added another staff member got the resident a different sling that was supposed to stay with her and it was grayish in color. Staff A and Staff B proceeded with the transfer to the bed. The transfer went smoothly and the sling removed once the resident laid in bed. During an interview on 1/6/25 at 3:15 p.m., Staff A, CNA queried on how she knew what size of mechanical sling size to use for each resident stated the slings were colored coded to the maker and some had tags on them with the weights. Staff A stated the weight was not the only factor, it depended on how wide the resident was too. Staff A stated the green corded sling was mid-level and the royal blue were the biggest ones and Resident #4 and Resident #5 needed the largest ones. Staff A stated she wasn't able to get Resident #5 out of bed twice due to no slings available. During an interview on 1/8/25 at 3:00 p.m., Staff A, CNA queried on what size sling Resident #2 needed for mechanical lift transfers. Staff A went into the bathroom and looked at the slings and lifted a tan sling with reddish border with a #73 and XXL (2x-large) written on it with permanent marker. 2. The MDS assessment dated [DATE] revealed Resident #4 scored a 11 out of 15 on the BIMS exam, which indicated cognition moderately impaired. The MDS revealed impairment in both lower extremities; used a wheelchair; and dependent with transfers from chair/bed to chair transfers. The MDS revealed diagnoses of Guillain- Barre syndrome and depression. The Care Plan, date initiated 9/9/20 included a Focus area to address [Name redacted] has an ADL self-care performance deficit related to impaired balance, limited mobility. Interventions included, in part: TRANSFERS with Hoyer and 2 aides, dated initiated 9/9/20. The Care Plan, date initiated 6/1/22 included a Focus area to address [Name redacted] is Risk for Falls r/t (related to) need for assistance for ADL's, incontinence, diagnosis, hallucinations, delusions and high-risk medications. Interventions included, in part: Transfer with Hoyer and 2 aids, make sure to open legs of Hoyer before lowering resident into w/c (wheelchair). Make sure Hoyer is operating properly before use and inform maintenance if Hoyer is not operating properly. Do not use Hoyer if not operating properly. Make sure Hoyer is rated for weight of resident, dated initiated 7/7/23. A review the Weight Summary, dated 1/7/25 revealed Resident #4 weighed 295.9 pounds on 1/4/25 at 8:58 p.m. During an observation on 1/6/25 at 1:37 p.m., Staff C, CNA and Staff D, CNA transferred Resident #4 with the mechanical lift. The sling had green [NAME] and a royal blue center. The sling did not cover the left side of the resident bottom. The transfer went without incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/25 at 9:42 a.m., Staff D, CNA queried on how she knew what size of mechanical lifts slings to use on each resident stated they used the bigger slings on the larger residents. Staff D stated they used a large or x-large on Resident #4. Staff D stated the sling size marked on the top of the sling by the [NAME]. Staff D held up a black corded sling with mesh in the center and stated that sling was a full body sling and they used it for residents 350 pounds and larger. Staff D held up a green corded sling with blue mesh and stated this sling used for residents who weighed between 200-250 pounds. Staff D asked if the green corded sling big enough for Resident #4. Staff D stated the other ones were dirty and Resident #4 needed a shower and they needed to put her in the shower chair so they used the smaller one. Staff D stated they don't do that normally, but she wanted her shower done. Staff D asked if she thought it was safe to use a smaller sling and she stated she didn't do it by herself, someone with her. During an interview on 1/7/25 at 10:03 a.m., Staff C, CNA queried on the sizes of the mechanical lift slings stated the black ones are the larger ones, but it depends on the company. Staff C stated they used the black edging the most. Staff C stated the green [NAME] was a medium size. Staff C asked if she used a green [NAME] on Resident #4 yesterday and she stated she didn't remember but she thought for Resident #4 the green one fit her well, it just depended on how we placed her. During an interview on 1/7/25 at 10:21 a.m., Staff J, CNA queried on how she knew what size of mechanical sling to use for each resident stated she didn't know the sizes. Staff J stated she held up the slings and knew the sizes by looking at them. Staff J asked if the green corded slings appropriate to use with Resident #4 and she stated no, because she would be hanging out of it. Staff J asked what size she would use for Resident #2 and she stated she used the gray one with black trim. During an interview on 1/7/25 at 11:11 a.m., Staff L, Central Supply queried about the ordering of slings in the last month and she stated she had a sling coming in this week and had put in a request order a couple of weeks ago and they were denied. Staff L stated she didn't know why they were denied and assumed due to budget and pushed them back through again and they were denied again with a comment they would get from a sister facility. Staff L stated she ordered a full body sling on 1/3/25 and it would arrive this week. During an interview on 1/9/25 at 10:35 a.m., the DON (Director of Nursing) queried on how they knew if they had enough slings stated a staff member told her in verbal report that a staff member threw the slings away and asked how were they supposed to know what they needed if staff just threw them away. The DON asked the staff if knew which sling to use on which resident and she stated it should be on the resident's care plan or Kardex. After the DON informed the sling sizes for Resident #2 and Resident #4 were not found on their Care Plans, she stated they needed to be. The DON stated they needed to put new processes in place and needed a binder with the sling sizes for each resident. The DON stated she recognized the concern. The DON confirmed the sling used to transfer Resident #2 and Resident #4 were too small and the staff should have used a larger sling for each resident to ensure safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 12:12 p.m., the Administrator queried on the the order for slings in December being denied and she stated because they had plenty of slings on hand and they used to have 80 people in the facility and the facility was oversupplied. The Administrator stated she didn't know they had a CNA throwing slings away, and they usually took the slings to Staff L when they were torn and Staff L put in a request when we needed more slings, but they take a few days to get slings in so she brought some from the other building. The Administrator stated she brought 4 the first time and brought another 10 another day and waited on the ones ordered. The Administrator stated the ordered had been denied for new slings because she was told they had enough in the building. The Administrator stated the housekeeper kept track of the slings. The Administrator stated she didn't know how the housekeeper kept track of the sling sizes, and now the DON will have a binder and that made more sense because she would know what the residents needed. The Administrator informed of the transfers with inappropriate sling sizes used, and confirmed the practice wasn't safe. The facility did not submit information regarding the weight recommendations for the mechanical lift slings used at the facility as requested. A review of the policy, dated 10/24, titled The Safe Lifting and Movement of Resident included a Policy Statement which declared: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move resident. The Policy Interpretation and Implementation section directed staff, in part to: 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. 9. Enough slings, in the sizes required by residents in need, will be available at all times. As an alternative, residents with lifting and movement needs will be provided with single-resident use disposable slings. 26529 3. A review of a facility self-reported incident, dated 10/8/24 revealed an incident between Resident #7, Resident #8 and Resident #9 when the residents were outside smoking without staff supervision. An undated facility policy, titled Smoking Policy included the following directives: a. The IDCP (Interdisciplinary Care Plan) team will review all residents who are participating in the smoking program on a one to one basis. Failure to comply with the smoking policy will result in counseling and may result in suspension of their smoking privileges. b. Residents will be assessed for safety using the Smoking Assessment Form. This is done prior to allow them to smoke and quarterly or with a significant change in condition thereafter. The assessment will also determine if the resident is in need of special provisions. c. Residents will be required to sign a copy of this policy and procedures to participate in this program. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the electronic health record revealed: a. The MDS assessment for Resident #7, dated 9/2/24 revealed no cognitive assessment completed. The 10/8/24 facility self-reported incident identified Resident #7 as Severely Impaired Cognition. HX (history): [Name redacted] has a history of accusing staff and residents of stealing items from him. He also has a history of making physical violence threats. A review of a Smoking Safety Assessment, dated 6/17/24 indicated Resident #7 had balance problems while sitting or standing, followed the facility's smoking protocols, and able to smoke independently. The electronic health record lacked an updated Smoking Safety Assessment. Resident#7 electronic health record included a signed acknowledgment, dated 10/14/24 indicating he read and understood the rules of the facility in regard to smoking. b. The MDS assessment for Resident #8, dated 8/1/24 revealed a BIMS score of 15 out 15, which indicated intact cognition. The MDS indicated the resident unable to ambulate, and required substantial assistance for position changes. A review of the Smoking Safety Assessment, dated 12/6/23 indicated Resident #8 followed the facility's smoking policy, and determined the resident could smoke safely alone. The electronic health record lacked an updated Smoking Safety Assessment, and a signed acknowledgment of the facility smoking policy rules. c. The MDS assessment for Resident #9, dated 7/17/24 revealed a BIMS score of 15 out of which indicated intake cognition. A review of the Smoking Safety Assessment, dated 4/18/24 revealed no identified concerns and Resident #9 could smoke independently. The electronic health record lacked an updated Smoking Safety Assessment, and a signed acknowledgement of the facility smoking policy rules. During an interview on 12/23/24 at 9:07 a.m., the former DON stated the new smoking policy was put into place right after the 10/7/24 incident. She stated there were 3 set times the residents could smoke outside, they had to be supervised by staff, and the resident's that smoked had to have a smoking safety assessment completed, and sign a consent for acceptance of the smoking rules and restrictions. The DON stated the Social Worker was who was responsible for completing the smoking safety assessments and getting the consents, and the assessments were supposed to be competed quarterly and as needed. During an interview on 1/7/25 at 2:39 p.m., Staff F, facility Social Worker, stated she completed the resident smoking assessments and got the Smoking Policy forms signed by the residents, she was supposed to do the assessments yearly, or if she noticed a change and she was the one who supervised the resident's smoking at least 1 of the times on the day shift and she would know if residents had any change in their ability to smoke independently. When asked where the Smoking Policy forms/consents would be located for Resident's #8 and #9, Staff F stated they might be in her desk, she would have to check on that. Updated Smoking Safety Assessments and signed Smoking Policy forms were not provided by the facility.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26529 Based on facility record review, staff interviews, and clinical record review the facility failed to ensure sufficient staff were on duty, including a licensed nurse, to meet the needs of the residents. The nurse on duty left the faciity on [DATE] and 12/16/24, and 6 of 6 insulin-dependent diabetic residents (Resident's #1, #5, #12, #15, #16 and #17) did not receive their insulin or have their blood sugars assessed for their lunch and supper time doses. On 12/31/24 the night shift nurse was alone in the facility for approximately 45 minutes until a staff member returned to work. On at least 4 occasions (10/23/24, 12/13/24, 12/14/24 and 12/24/24) the scheduled nurse on duty was forced to work in excess of 17 hours without replacement. The facility reported a census of 35 residents. Findings include: 1. The Daily Staff Assignment sheet dated 12/13/24 revealed the following: The Director of Nursing (DON) identified as Registered Nurse (RN) coverage. Day nurse (6 a.m. to 6 p.m.) Staff S, RN's name was crossed through, and Staff I, Licensed Practical Nurse (LPN) assigned. Certified Medication Aide (CMA) 6 a.m. to 2 p.m. Staff J, CMA Certified Nursing Assistant (CNA) 6 a.m. to 2 p.m. Staff D, CNA, Staff U, CNA CMA 2 p.m. to 10 p.m. Staff V, CMA CNA 2 p.m. to 10 p.m. Staff A, CNA, Staff M, CNA Night nurse (6 p.m. to 6 a.m.) Staff H, LPN's name crossed through, and Staff P, Agency LPN assigned. CNA 10 p.m. to 6 a.m. Staff W, CNA, Staff X, CNA Review of Payroll Reports revealed the following: Staff H, LPN worked from 6:30 p.m. on 12/12/24 to 7:15 a.m. on 12/13/24, and Staff I, LPN worked on 12/13/24 from 7:15 a.m. to 11:45 p.m., Staff P, agency LPN worked from 10 p.m. on 12/13/24 to 5:00 p.m. on 12/14/24, and Staff S, RN, worked from 5 p.m. on 12/14/24 to 6:15 a.m. on 12/15/24. Staff H, LPN worked from 6:00 a.m. to 6:40 p.m. on 12/16/24. Observation on 12/31/25 at 9:23 a.m. revealed a sign posted on the Medication Room door at the Nurse's Station that stated: Reminder, if you are the only nurse in the facility you are not allowed to leave the premises. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/31/25 at 9:55 a.m., Staff D, CNA, stated she worked the day shift on 12/13/24, Staff I, LPN was the nurse on duty for 6 a.m. to 6 p.m. shift and left the facility between 10:30 a.m. and 10:45 a.m. The DON was in her office with the door closed, staff realized the DON left the facility between 11:30 a.m. and 12 p.m. when they looked for her in Staff I's absence. There was no nurse in the facility at that time and staff messaged the Administrator. The Administrator called back before Staff D left work, said she spoke to Staff I and she was on her way back to the facility, but Staff D didn't see Staff I in the facility when she left for the day at approximately 2:15 p.m. During an interview on 12/31/24 at 11:38 a.m., Staff I, LPN, stated when she was called in to cover a nursing shift there were a few times she had to leave the facility as she had prior appointments scheduled. When she did that she let the DON know and gave her the keys to the medication carts, and she had the DON's authorization to leave the facility. Staff I couldn't recall the dates, stated one of the times it was 2 hours for a doctor appointment and the other time it was for 4 hours for a car appointment. Staff I stated she knew they always had to have a nurse at the facility. During an interview on 1/2/25 at 11:01 a.m. the DON stated Staff I, LPN, never gave her the keys to the medication carts when she was the nurse on duty, or told her that she had to leave the facility. The DON stated Staff I left on breaks and thought she left the keys in their office. When asked if she left the faciity on [DATE], the DON stated she had to check her calendar. At 11:08 a.m. the DON stated she was off on 12/13/24 and was not in the facility on that day. During an interview on 1/2/25 at 11:40 a.m., Staff M, CNA stated one day when she came in for her 2 p.m. shift, there was no nurse there. Staff I, LPN was supposed to be there as the nurse but she wasn't, and the DON wasn't there either. The day shift said Staff I had been gone since before 11 a.m., there was a CMA there who spoke to the Administrator on the phone about it. Staff I did come in around 3 p.m. that day. During an interview on 1/2/25 at 12:02 p.m., Staff A, CNA, stated she usually worked on the evening shift, there were at least two times that Staff I, LPN, left the facility when she was the only nurse on duty. One time was 12/13/24. Staff I wasn't in the facility when she arrived to work at 2:00 p.m. that day. She came in by 3:00 p.m. and there was another time that she left to go a store and came back with pizza for some of the residents, she wasn't sure of the date but it was within a week of the other time. During an interview on 1/2/25 at 12:35 p.m. Staff V, CMA, stated she remembered there was a day when Staff I was the nurse and she was gone for a while. One of the CNA's called the Administrator and let her know she was gone. Staff V worked the evening 2 p.m. to 10 p.m. shift on 12/13/24 when that occurred. During an interview on 1/9/25 at 11:15 a.m. the DON stated the Administrator notified her that Staff I, LPN, was leaving the facility, as staff were reporting it to the Administrator and not to her. She addressed this with Staff I, instructed her that she couldn't leave the facility if she was the only nurse on duty. The DON stated she thought the staff lied about Staff I leaving while on duty, that she didn't leave. The DON stated Staff I reported to her, and didn't know what time she would be at work today as she set her own hours (Staff I not in the facility as of the time of this interview and scheduled as the MDS nurse on this day). The DON stated she didn't post the sign about the requirement for a nurse to remain in the facility, she thought the Administrator posted the sign. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/9/25 at 1:04 p.m., the Administrator stated she was notified one time by one staff, Staff A, CNA, on 12/13/24 at 2:14 p.m. via text message that Staff I wasn't in the facility. The only other information she knew about that day was a message from Staff I at 3:05 p.m., that said to read her email. The Administrator did not offer the email message for documentation. The Administrator stated she did not post the sign about the requirement for a nurse to remain in the facility, and would take it down. She expected nursing staff to remain in the facility if they were the only nurse on duty. Resident record review revealed the following insulin-dependent diabetic residents had not received their scheduled lunch and supper time insulin, or had their blood sugar checked at those times as ordered on 12/13/24 and 12/16/24: A). Resident #1 had physician orders that included: Check blood sugar (BS) 3 times daily before meals and at hour of sleep (HS). Administer Lispro insulin subcutaneous (fat cells below the skin) per sliding scale 3 times daily before meals and at hour of sleep. B). Resident #12 had physician orders that included: Check BS 3 times daily before meals. Administer 55 units of Lantus insulin subcutaneous every morning and afternoon. Administer Humalog insulin per sliding scale order 3 times daily before meals. C). Resident #14 had physician orders that included: Check BS 3 times daily before meals and at HS. Administer 52 units Tresiba insulin subcutaneous every morning and afternoon. Administer 27 units Lispro insulin subcutaneous 3 times daily before meals. Administer Lispro insulin subcutaneous per sliding scale 3 times daily before meals. D). Resident #15 had physician orders that included: Check BS before meals and at HS. Administer 20 units Lispro insulin 20 units 3 times daily before meals. E). Resident #17 had physician orders that included: Check BS 3 times daily before meals. Administer 12 units Lispro insulin subcutaneous 3 times a day before meals. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer Lispro insulin subcutaneous per sliding scale 3 times a day before meals. 2. The Daily Staff Assignment sheet dated 10/23/24 revealed the following: Day Nurse (6 a.m. to 6 p.m.) Staff P, LPN and Staff BB, RN Night Nurse (6 p.m. to 6 a.m.) Staff AA, RN The October, 2024 Employee Termination Report revealed Staff AA, RN, resigned from employment on 10/16/24. During an interview on 12/23/24 at 9:07 a.m., the former DON, the Regional Nurse Consultant for the facility's corporation, stated on 10/23/24, Staff P, LPN notified her that there was no nurse coverage for the night shift, and she had to return to the facility as they could not find another nurse to work. The former DON stated she had already taken her medication when Staff P contacted her, and had to wait before she returned to work for safety reasons. She returned to the facility around 11:30 p.m. and didn't see Staff P, she had already left and left the keys to the medication carts at the Nurse's Station. The DON stated as she worked that night she learned that Staff P had not administered any evening medications, and she was terminated as a result of that and she had left the facility before she got there. The former DON documented the following Nursing Progress Note entry in every resident's record that had evening medication or treatment orders that had not been completed by Staff P, LPN on 10/23/24: On 10/24/24 at 7:44 a.m. it appears that multiple residents did not receive their evening/HS medications. Total of 27 Residents were affected. The nurse on duty was terminated and there was no adverse effect from missing meds during that time. Education to be conducted to all nursing staff and an adhoc QAPI will be conducted. During an interview on 1/9/25 at 7:21 p.m., Staff P, LPN, stated she was scheduled to work 6 a.m. to 6 p.m. on 10/23/24. The assignment sheet said Staff AA, RN was scheduled to work 6 p.m. to 6 a.m., the problem was Staff AA had quit the week before. She said something about the schedule to the DON before she left for the day, and she told Staff P that Staff I, LPN was going to cover it. Staff P stated she was friends with Staff I and knew she had been sick. When Staff I didn't come in at 6 p.m. she called her and Staff I said she was sick and the DON knew that she wasn't able to work that night. Staff P stated she called the Administrator and the DON, and had to leave a message for the DON. When the DON called back she said she would try to find someone to come in, there was still no relief nurse at 10 p.m. Staff P called the Administrator and the DON again, the DON said she would come in, she wasn't there at 11 p.m. Staff P called her again and she said she was on her way. Staff P stated the DON arrived around 11:30 p.m., after Staff P had been on duty for 17 and a half hours. 3. The Daily Staff Assignment sheet dated 12/14/24 revealed the following: Staff S, RN identified as RN Coverage Day Nurse Staff S, RN's name crossed through, Staff P, LPN assigned (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CMA 6 a.m. to 2 p.m. Staff O, CMA CNA 6 a.m. to 2 p.m. Staff D, CNA, Staff Y, CNA's name listed as called in CNA 2 p.m to 10 p.m. Staff B, CNA, Staff Z, CNA Night Nurse Staff Q, LPN's name crossed through, Staff S, RN assigned During an interview on 1/9/25 at 7:21 p.m., Staff P, LPN, stated she had to work over 17 hours again when she worked at the facility as an agency nurse. She relieved Staff I, LPN at midnight on 12/13/24, Staff I had been there since that morning as the only nurse. There was an ice storm predicted for 12/14/24, it had been predicted for at least 2 or 3 days. When she was the Assistant Director of Nursing (ADON) at the facility, if there was bad weather, management planned around it, knowing there was a good chance some staff would not make it in. They either offered overtime for staff to work double shifts, or the managers planned to be at work to help, but that is not the case with the current DON. When Staff P worked the overnight shift on 12/13 to 12/14/24, she was scheduled to work on 12/14/24 from 6 p.m. to 6 a.m. at another facility through her staffing agency, she needed to get home to sleep. On the morning of 12/14/24, the nurse scheduled to work the day shift called in sick. Staff P stated she immediately called the DON who said she lived too far away and there was an ice storm, she would not come to the facility. Staff P called the Administrator who said she would try to find someone. Staff P stated the nurse scheduled to work the night shift on 12/14/24 was off work for a health problem and there was no coverage for that either. She spoke to the Administrator a few times, who kept telling her she was working on it, and yet there was no relief staff for her throughout the day. Staff P's staffing agency told her to call the police and turn the facility keys over to them, they would evacuate the facility then. The Administrator called her later and said Staff S, RN would come in to relieve her, she didn't get there until nearly 5 p.m., after Staff P had worked 17 hours straight without relief. During an interview on 1/9/25 at 1:04 p.m., the Administrator stated on 12/14/24, she spoke to Staff P and informed her she would try to find coverage. She made several phone calls to staff at both the facility and sister-facility, and while making the calls her phone was being blown up by Staff P's staffing agency, who demanded that Staff P turn the keys over to the police and they were going to evacuate the facility if the Administrator couldn't get staff there to relieve her. The Administrator was able to get Staff S to the facility to relieve Staff P. The Administrator had checked with staffing agencies for coverage and there were no staff available that day. 4. The Daily Staff Assignment sheet dated 12/24/24 revealed the following: Day Nurse Staff R, LPN Night Nurse Staff H, LPN name crossed though and Staff I, LPN assigned Review of Payroll Records revealed Staff R, LPN worked on 12/24/24 from 6:00 a.m. to 11:00 p.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/31/24 at 10:44 a.m., Staff R, LPN stated on 12/24/24, she had to work for 17 hours. The nurse scheduled to work the 6 p.m. to 6 a.m. night shift was in the hospital and they had not found anyone to cover her shift, she was forced to stay until she was relieved by Staff I, LPN, who had to come in to relieve her. She tried to call the DON, but didn't get an answer and she didn't return her call. She contacted the Administrator about it and she said she was working on it, and that is how she was relieved by Staff I. Per staff interviews and facility records, the nurse on duty had to work a minimum of 17 hours without relief due to lack of nurse coverage on 10/23/24, 12/13/24, 12/14/24 and 12/24/24. 5. The Daily Staff Assignment sheet dated 12/31/24 revealed the following: DON listed as RN Coverage Day Nurse Staff R, LPN CNA 2 p.m. to 10 p.m. Staff M, CNA, Staff B, CNA, and Staff A, CNA scheduled for 2 p.m. to 6 p.m. for showers. Night Nurse Staff Q, LPN's name was crossed through, Staff I, LPN's name was assigned. CNA 10 p.m. to 6 a.m. Staff DD, CNA's name crossed through, Staff M CNA's name written as replacement, and an agency CNA A Payroll Report revealed Staff M, CNA, worked from 2:00 p.m. on 12/31/24 to 6:00 a.m. on 1/1/25, and had not clocked out at the conclusion of her scheduled 2 p.m. to 10 p.m. shift. During an interview on 1/2/25 at 9:10 a.m., Staff I, LPN, stated on 12/31/24 she worked as the MDS nurse until 3:30 p.m., left and returned at 6:30 p.m. to be the nurse on duty for the night shift. There were 2 CNA's scheduled for the 10 p.m. to 6 a.m. night shift that had called off. Staff M worked as a CNA on the 2 p.m. to 10 p.m. evening shift, she left at 10 p.m., came back about an hour and a half later, then worked with her until 6 a.m. on 1/1/25. When Staff I was alone in the facility, she answered call lights, didn't transfer any residents to or from bed, and she had called the Administrator to get help when she learned the scheduled night shift CNA's wouldn't be there. During an interview on 1/2/25 at 11:40 a.m. Staff M, CNA, stated she was on duty for the 2 p.m. to 10 p.m. evening shift on 12/31/24, both of the CNA's scheduled for the 10 p.m. to 6 a.m. night shift had called in, Staff I, LPN was the nurse on duty, she'd called the Administrator and DON for help but couldn't get help. Staff M stated she felt horrible that Staff I would have to work as the only staff, Staff M had to go home at the end of her shift to care of her dogs, then returned to the facility 30 to 45 minutes later to work with Staff I until 6 a.m. so she wouldn't be there alone. During an interview on 1/2/25 at 11:01 a.m., the DON stated staff did not notify her the scheduled night shift CNA's on 12/31/24 had called in, they called the Administrator, and she wouldn't have been able to help as she was out of town. (continued on next page)

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Aspire of Muscatine	2002 Cedar Street Muscatine, IA 52761

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/8/25 at 2:48 p.m., Staff M, CNA, stated when she worked the double shift on 12/31/24, she did not clock out when she went home at 10 p.m. because she had not had a break that evening, and used her break to go home and then return to the facility for the night shift. During an interview on 1/9/25 at 1:04 p.m., the Administrator stated on 12/31/24 she was on the phone for quite a while with the Staffing Agency, as the CNA assigned had not shown up. The Staffing Agency initially reported that he drove to the wrong facility and was on his way there, and then at 1 a.m. when he had not reported to work, the Staffing Agency canceled the

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 26529 Based on facility document record review, observations and staff interviews, the facility failed to provide 8 consecutive hours of staffing by a Registered Nurse (RN) daily as required by regulation on at least 6 days in December, 2024 (12/1/24, 12/4/24, 12/13/24, 12/21/24, 12/24/24 and 12/31/24). The facility reported a census of 35 residents. Findings include: Review of nursing schedules and payroll records revealed nursing staff worked 12-hour shifts, from 6:00 a.m. to 6:00 p.m. and from 6 p.m. to 6 a.m. The documents reviewed for the month of December, 2024 revealed the following: On 12/1/24 Staff P, Licensed Practical Nurse (LPN) worked the day shift and Staff Q, LPN worked the night shift. On 12/4/24 Staff R, LPN worked from 6 a.m. to 7:15 p.m., Staff I, LPN worked from 7:15 p.m. to 12:15 a.m. and Staff P, LPN worked from 12:01 a.m. to 8:22 a.m. on 12/5/24. On 12/12/24 Staff H, LPN worked from 6:30 p.m. to 7:15 a.m. On 12/13/24, Staff R, LPN worked from 7:15 a.m. to 11:45 p.m., Staff P, LPN worked from 10:00 p.m. to 5:00 p.m. on 12/14/24. On 12/20/24 Staff I, LPN, worked from 6:30 p.m. to 6:00 a.m. On 12/21/24, Staff R, LPN worked from 6:00 a.m. to 7:30 p.m. and Staff I, LPN worked from 7:15 p.m. to 6:00 a.m. on 12/21/24. On 12/24/24 Staff R, LPN worked from 6:00 a.m. to 11:00 p.m., and Staff I, LPN worked from 11:00 (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	p.m. to 6:00 a.m. on 12/25/24. The Director of Nursing (DON) was not in the facility and worked from home. On 12/30/24 Staff Q, LPN worked the night shift, Staff R, LPN worked the day shift on 12/31/24, and Staff I, LPN worked the night shift until 6:00 a.m. on 1/1/25. Observations on 12/31/24 revealed the DON arrived at the facility at 9:10 a.m., and left the facility for the day at 2:45 p.m. During a telephone interivew on 12/24/24 at 9:10 a.m., the DON stated she was working from home that day. During an interview on 12/31/24 at 11:01 a.m., the DON stated she did not work/was not in the facility on 12/13/24. During an interview on 12/31/24 at 9:55 a.m., Staff D, CNA, stated the DON usually arrived after 9 a.m., left by 3 p.m. and was usually in her office with the door closed. During an interview on 1/9/25 at 11:15 a.m., the DON stated she drove 1 hour and 40 minutes each way to work, she had 4 children at home every other week, could not be at the facility for 8 hours on those days and going forward she would coordinate her schedule with Staff S, the facility's only RN, to ensure the facility had 8 hours of RN coverage daily.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 26529 Based on clinical record review, facility assessment, and staff interviews, the facility failed to ensure facility staff had the sufficient competencies and skills sets to provide nursing and related services for residents with mental health diagnoses, and behavioral disturbances requiring intervention. The facility has 12 of 35 residents with Level II Pre-Admission Screening and Resident Review (PASRR) in place. Findings include: A Level II Pre-Admission Screening and Resident Review (PASRR) Evaluation is a comprehensive assessment that determines if a person required long-term care in a nursing facility and completed for people who test positive on a Level I PASRR Screening. The Level II PASRR Evaluation confirms that a person has a serious mental illness, and identifies the types of specialized services required by the person that may include a) behavior monitoring and management, b) monitoring of psycho-active medications to determine the effects on behavioral symptoms, c) therapeutic counseling by facility staff, and d) on-going service integration that could include regular care by a Psychiatrist or Psychiatric Nurse Practitioner to manage the person's medication regimen for optimization on the targeted symptoms. The Level II PASRR document directs the care that is required for the individual when they are admitted to a long-term care facility. The Facility Assessment, dated 12/3/24 revealed the Common Diagnoses/Conditions for the category Psychiatric/Mood Disorders the facility indicated they are may accept included: Psychosis (Hallucinations, Delusions, etc), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e, Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder (PTSD), Anxiety Disorder, Behavior that Needs Intervention. The Assessment Special Treatment and Conditions identified for the problem of Mental Health, with a Special Treatment of Behavioral Health Needs indicated the Number/Average or Range of Residents as 18 (eighteen), with the Special Treatment of Active or Current Substance Use Disorders Number/Average or Range of Residents as 2 (two). The Assessment identified the Services Provided Based on Resident Need for the General Care area of Mental health and behavior, Specific Care or Practices included: a. Management of medical conditions and medication-related issues causing psychiatric symptoms and behaviors. b. Identify and implement interventions to support individuals with issues such as dealing with anxiety. 3. Care for residents with cognitive impairment, depression, psychiatric diagnoses and trauma/PTSD. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility Assessment identified Staff Competency to be completed on annually, on hire and PRN (as needed) in the areas of: Caring for People with Dementia, Alzheimer's and Cognitive Impairments, Caring for residents with Mental and Psychosocial disorders, Non-pharmacological management of Responsive Behaviors Staff training/education and competencies required for care of their residents that included, in part: Care/management for persons with dementia, Alzheimer's disease and cognitive impairment. The facility's undated Certified Nursing Assistant Skills Competency Validation Checklist, completed upon hire and annually, did not list behavior management, care for residents with cognitive impairment or dementia symptoms, mental illness, trauma or PTSD as required skills. Review of education and training topics provided for facility staff during the previous 12 months did not include education on the identified topics. A review of facility self reported incidents revealed resident to resident altercations involving Resident #7 with three other residents. The Minimum Data Set (MDS) Assessment for Resident #7, dated 9/2/24 revealed no cognitive assessment completed. Resident #7 identified as usually able to make himself understood, always understood others and without behaviors. The electronic health record Medical Diagnosis list for Resident #7, dated 12/23/24 included, in part: unspecified dementia, unspecified severity with behavioral disturbance as secondary diagnosis on 7/16/24, and violent behavior as secondary diagnosis on 7/16/24. Resident #7's Care Plan, initiated on 6/22/24 included a Focus area to address [Name redacted] is a risk for increased verbal and physical behaviors r/t (related to) increasing depression r/t being in facility, accuchecks (blood sugar checks) not in control and other health concerns. The Focus area included, in part: a. [Name redacted] has been involved in a res (resident) to res altercation. b. [Name redacted] hit and injured a staff member and was sent out via ambulance and police called on 7-15-24 c. 10/7/24 Resident hit and threatened residents and accusing them of stealing his cigarettes. d. 10-8-24 Resident was verbally aggressive towards other in the dining room. Date initiated: 6/22/24. e. [Name redacted] has had an altercation and was the recipient of physical aggression. Dated initiated: 10/7/24. Interventions included, in part: a. Referral to [provider name redacted] psychological/psychiatric services as first available appointment. Dated initiated: 6/22/24 (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Separate from others res for safety. Date Initiated: 6/22/24 c. 10-8-24 Referrals being sent to CCDI (Chronic Confusion and Dementing Illness) Units in Iowa that are more appropriate for his needs. Dated initiated: 10/8/24. During an interview on 12/31/24 at 2:22 p.m., Staff A, Certified Nursing Assistant (CNA) stated Resident #7 had aggressive behaviors towards other residents and staff, he was unpredictable, threw things, at times she was afraid of him and didn't know what to do to calm him when he was so agitated. During an interview on 1/9/25 at 7:21 p.m., Staff P, Licensed Practical Nurse (LPN) stated she had worked at the facility both as an employee and through agency for 3 to 4 years, there were several residents at the facility that had behaviors, some were difficult to manage and redirect, the resident's that had behaviors effect the other residents and staff and can cause behaviors in other residents. Staff at the facility did not receive training or support to manage resident behaviors, if a resident required 1 to 1 supervision for safety due to behaviors there was seldom enough staff at the facility to accomplish that. During an interview on 1/23/25 at 1:38 p.m., Staff O, CNA, stated she had worked at the facility several years, she received dementia training at another facility several years ago, but had not had any behavior management training at the facility since she worked there. She learned through working there that when Resident #7 was aggressive, the best approach was calmly by 1 person, not to have several staff respond at the same time, and to gently try to guide him to his room to calm down in a quiet area. During an interview on 1/23/25 at 1:41 p.m. Staff N, CNA, stated she had worked at the facility for 2 weeks, had not had any training about resident behaviors or what to do. She thought if a resident had behaviors she would yell for help if she needed to. Staff N stated she was not aware and had not been directed to monitor Resident #7 for behaviors or if there were any residents that they were supposed to keep him away from other residents. During an interview on 1/23/25 at 2:54 p.m. Staff G, CNA, stated she worked at the facility for a year, had not had any training on resident behaviors or what to do, and if a resident had behaviors she would get the nurse. During an interview on 1/23/25 at 2:57 p.m. Staff B, CNA, stated she had not had any training at the facility to manage resident behaviors, if a resident had behaviors or got aggressive she would get the nurse and stay away from them. During an interview on 1/23/25 at 3:18 p.m., the Interim Administrator stated the Director of Nursing (DON) had planned to provide staff education on behavior management of residents in December, 2024 and provided some program materials for the education that included 10 Ways to Defuse Disruptive and Abusive Resident Behavior, Managing Behaviors and Managing Resident Counterproductive Behaviors. During an interview on 1/28/25 at 1:06 p.m., the Interim Administrator stated the Behavior Management in-service was scheduled on 1/30/25, it was mandatory for the nursing staff, and the DON would provide the education.

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 01/28/2025
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are free from significant medication errors. 26529 Based on clinical record review, facility document review, resident interview, staff and physician interviews, the facility failed to administer evening insulin medication to insulin-dependent diabetic residents and failed to assess resident blood sugars as ordered by the physician as many as 14 times during the month of December, 2024 for 5 of 5 residents with evening insulin orders (Resident's #1, #5, #7, #15 and #16). The facility reported a census of 35 residents. Findings include: 1. Resident #1's Minimum Data Set Assessment tool dated 12/4/24 revealed the resident scored 15 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated no cognitive impairment or symptoms of delirium present, and always able to make herself understood and always understood others. The Clinical Physician Orders for Resident #1 last reviewed 12/3/24 included: Check blood sugar (BS) 3 times per day before meals and at hour of sleep (HS). Administer 40 units Glargine insulin subcutaneously (in the fat cell area under the skin) every morning and HS. Administer Lispro insulin subcutaneously per sliding scale 3 times daily before meals and at HS. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for December 2024 revealed: -No HS insulin or BS checks completed on 12/2/24, 12/9/24, 12/11/24, 12/12/24, 12/13/24, 12/16/24, 12/18/24, 12/21/24, 12/23/241 and 12/25/24. -BS not checked/no sliding scale insulin at noon and supper on 12/13/24 and 12/16/24. -Staff H documented she completed the resident's HS insulin administration and BS check on 12/10/24, 12/17/24 and 12/19/24. The Care Plan included a Diabetes Mellitus problem, initiated 9/17/24 that directed staff: a). Administer diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, initiated 9/17/24. b). Monitor/document/report as needed any signs or symptoms of hyperglycemia (high blood sugar): increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, acetone breath (smells fruity), stupor, coma, initiated 9/17/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c). Monitor/document/report as needed any signs or symptoms of hypoglycemia (low blood sugar): Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait, initiated 9/17/24. During an interview on 1/2/25 at 2:49 p.m., the resident stated there were times recently that staff didn't administer her insulin after supper or check her blood sugar, and she told the nurses that she hadn't received it. 2. The Clinical Physician Orders for Resident #5 last reviewed 12/3/24 included: Check BS twice daily in the morning and at HS. Administer Jardiance 25 milligrams (mg) oral daily (oral hypoglycemic medication for diabetics). Administer 22 units Lantus insulin subcutaneously every HS The MAR and TAR dated December 2024 revealed: -No HS insulin or BS checks were completed on 12/9/24, 12/10/24, 12/11/24, 12/12/24, 12/16/24, 12/17/24, 12/18/24, 12/19/24, 12/21/24, 12/23/24 and 12/25/24. -Staff H documented she completed the resident's HS BS check and insulin administration on 12/2/24. The Care Plan for Resident #5 included an Insulin Dependent Diabetes problem initiated 2/22/23 that directed staff: a). Administer diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, initiated 2/22/23. b). Monitor/document/report as needed any signs or symptoms of hyperglycemia (high blood sugar): increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, acetone breath (smells fruity), stupor, coma, initiated 2/22/23. 3. The Clinical Physician Orders for Resident #7 last reviewed 12/3/24 included: Check BS twice daily in the morning and HS. Administer 13 units Lantus insulin subcutaneously every morning and HS. The MAR and TAR dated December 2024 revealed: -No HS insulin or BS checks on 12/2/24, 12/9/24, 12/10/24, 12/11/24, 12/12/24, 12/17/24, 12/18/24, 12/19/24, 12/21/24, 12/23/24 and 12/25/24. -Staff H, LPN documented she administered the HS insulin and completed the BS check on 12/16/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Care Plan included a Diabetes Mellitus problem initiated 4/2/24 that directed staff: a). Administer diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, initiated 4/2/24. b). Monitor/document/report as needed any signs or symptoms of hyperglycemia (high blood sugar): increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, acetone breath (smells fruity), stupor, coma, initiated 4/2/24. 4. The Clinical Physician Orders for Resident #15 last reviewed 12/3/24 included: Check BS 3 times daily before meals and at HS. Administer 20 units Lispro insulin subcutaneously 3 times daily before meals. Administer 85 units Tresiba insulin subcutaneously every morning and HS The MAR and TAR dated December 2024 revealed: -No HS BS completed or insulin administered on 12/2/24, 12/9/24, 12/11/24, 12/12/24, 12/13/24, 12/16/24, 12/17/24. 12/18/24, 12/19/24, 12/21/24, 12/23/24 and 12/25/24. -No noon or supper insulin was administered on 12/13/24 and 12/16/24 Staff H, LPN documented she checked the resident's HS BS and administered HS insulin on 12/10/24. The Care Plan for Resident #15 had a Diabetes Mellitus problem initiated 9/6/18 that directed staff: a). BS checks per MD orders, initiated 2/6/20. b). Administer diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, initiated 9/6/18. c). Follow facility protocols for high and low blood glucose levels, initiated 5/16/24. d). Glucagon per order for symptomatic if BS < 60, initiated 5/16/24. 5. The Clinical Physician Orders for Resident #16 last reviewed 12/3/24 included: Check BS daily on the night shift (order start 12/9/24) Administer 21 units Lantus insulin subcutaneously every HS. The MAR and TAR dated December 2024 revealed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-No HS insulin was documented as administered on 12/2/24, 12/9/24, 12/10/24, 12/11/24, 12/12/24, 12/16/24, 12/17/24, 12/19/24, 12/21/24, 12/23/24, 12/25/24 and 12/31/24. -The resident's BS was not checked 12/9/24,12/10/24, 12/11/24, 12/12/24, 12/16/24, 12/17/24, 12/19/24, 12/21/24, 12/23/24 and 12/25/24. -Staff H, LPN documented she administer the resident's insulin on 12/2/24 and 12/18/24. The Care Plan for Resident #16 included a Diabetes Mellitus problem initiated 10/27/24 that directed staff: a). Administer diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, initiated 10/17/24. The Payroll Records revealed Staff H, LPN, worked on the 6 p.m. to 6 a.m. night shifts on the following dates in December: 12/2/24 12/9/24 12/10/24 12/11/24 12/12/24 12/16/24 12/17/24 12/18/24 12/19/24 12/21/24 12/23/24 12/25/24 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/31/24 at 12:18 p.m. Staff S, RN stated the evening insulins and blood sugars weren't being done when Staff H, LPN worked. Resident blood sugars are impacted, higher, 300+ the next day. Staff H says she doesn't care, she can't get them done when she's the only nurse, but that's not true, as all the nurses are the only nurses on duty and they can manage to get them done so Staff H should be able to do so as well. There was no reason not to give resident insulin or complete blood sugar assessments and Staff S thought this was a dangerous practice. Staff S stated she felt she wasn't Staff H's supervisor; the DON should do something about Staff H not giving insulin and checking blood sugars. During an interview on 1/2/25 at 11:01 a.m., the Director of Nursing (DON) stated she expected staff to administer medications, insulin and provide treatments as ordered by the physician, unless there was a contraindication and they should consult with the provider for direction if so. The DON stated she was not aware that Staff H didn't administer the diabetic resident's evening insulin or check their blood sugars as ordered until the Surveyor brought the matter to her attention, and expected staff to administer insulin, complete the ordered treatments, document they had done so and all staff were educated to do so today. The DON denied that staff or residents had notified her that Staff H had not administered insulin or checked blood sugars when she worked. The DON stated failure to administer a resident's ordered insulin without cause would be a medication error, and stated she had notified their Medical Director that Staff H had not administered HS insulin's or completed HS blood sugars as ordered. During an interview on 1/2/25 at 11:40 a.m., Staff M, Certified Nursing Assistant (CNA) stated she worked the 2 p.m. to 10 p.m. evening shift, had worked with Staff H several times, never saw her administer insulin or check resident blood sugars. There was a resident that asked for his insulin 1 night and she told Staff H. Staff H said she would do it, but the same resident asked again a couple hours later for it, said the nurse never came and didn't check his blood sugar either. During an interview on 1/2/25 at 6:05 p.m., Staff H, LPN, stated she worked at the facility for approximately 1 month on the 6 p.m. to 6 a.m. night shift, she transferred from a sister facility where she had worked on the same shift for about a year. Staff H stated she thought it was weird that the diabetics didn't have physician orders for evening insulin or blood sugar checks, and found out recently that their insulin and blood sugar orders were in a different part of the computer. She stated they weren't that way at the sister facility, she didn't know to check there, and said she never asked other staff why the residents wouldn't have evening insulin or blood sugar checks. When asked if any resident had asked for their insulin, Staff H stated no, then laughed. When asked if any staff had asked her or indicated that a resident wanted their evening insulin, Staff H stated staff had not said anything to her about residents wanting insulin. During an interview on 1/7/25 at 6:03 a.m., Staff Q, LPN, stated she worked at the facility's sister facility through staffing agency, worked at this facility for about 2 months, and medication, insulin and blood sugar orders were in the same place in the computer at both facilities. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/7/25 at 2:09 p.m. the facility's Medical Director Physician stated there was a lot of staff turnover at the facility and it was hard to know who was responsible for oversight of resident care there. The physician said he was not informed that the evening/night nurse did not administer HS insulin's or check HS blood sugars, and that was concerning to him. He would have to take that into account if any of the diabetics had HgA1C lab work (blood work that measures the blood sugar trend over a long period of time) in the near future. The physician stated he would speak with the DON about the issue. During an interview on 1/9/25 at 11:15 a.m. when copies of the Medication Error Report form for the non-administered insulin by Staff H were requested, the DON stated she had not completed any Medication Error Reports for the insulin not administered, staff were educated and Staff H no longer worked there.