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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Muscatine	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47079 Based on observations, staff interview, and policy review, the facility failed to ensure residents had a clean, well-maintained and homelike environment. The facility reported a census of 36 residents. Findings include: On 6/24/24 at 3:35 PM, a brown stain was noted on the floor at the entrance to Hall 1. On 6/25/24 at 10:17 AM, Staff G, Housekeeper mopped the Hall 1 floor and the stain was gone. On 6/27/24 on 7:50 AM, brown stains were noted on the north side of Hall 1. At 8:28 AM, Staff G stated she was the only housekeeper scheduled. She stated she was assigned to clean Halls 3 and 5 only and Staff H was scheduled to clean Halls 1 and 2 on 6/28/24. At 8:31 AM, Staff I, Housekeeping Supervisor stated she could help clean Halls 1 and 2 but the housekeeper who was scheduled to clean those halls was off today. She stated there was no staff scheduled to perform housekeeping duties for halls 1 and 2 today. At 11:02 AM, the Regional [NAME] President of Operations (RVPO) stated someone should be scheduled every day to clean each hall. A document titled Housekeeping Cleaning Principles dated 6/2016 indicated the facility would maintain common areas and resident rooms in a clean and sanitary condition. It also indicated cleaning of resident rooms would be performed daily.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 35434 Based on observation, clinical record review, policy review, and staff interviews, the facility failed to ensure emergency equipment such as an obturator (used to insert a tracheostomy tube, a tube inserted through the neck into the windpipe enabling a resident to breathe) was available at the bedside and staff were aware of how to replace the tube for 1 of 1 residents with a tracheostomy tube (Resident #15). Due to this failure, a serious adverse outcome was likely to have occurred if the resident experienced an extubation, therefore causing an Immediate Jeopardy (IJ) to the health, safety, and security of the resident. The facility also failed to carry out physician orders related to the resident's tracheostomy by not changing the tubing as ordered. The State Agency informed the facility of the IJ that began as of June 24, 2024 on June 26, 2024 at 10:50 a. m. The facility staff removed the IJ on June 27, 2024 through the following actions: a. Placement of an emergency tracheostomy kit in Resident #15's room. b. Staff education regarding the location of the emergency kit. c. Staff education regarding how to insert a tracheostomy tube. The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility reported a census of 36 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 5/15/24, listed diagnoses for Resident #15 which included respiratory failure, heart failure, and anxiety disorder. The MDS stated the resident received tracheostomy care and listed his Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. A 6/6/24 Care Plan entry stated the resident had a tracheostomy, was at risk for respiratory distress, and would have no complications related to the tracheostomy. Observations of the residents room on 6/25/24 at 9:44 a.m. and 10:36 a.m. revealed no emergency tracheostomy set with obturator. On 6/25/24 at 9:44 a.m. Resident #15 sat in a chair in his room with a tracheostomy tube in place. On 6/25/24 at 2:58 p.m., Staff A Registered Nurse (RN) was queried regarding the location of an emergency tracheostomy set for Resident #15. Staff A stated she needed to ask the Director of Nursing (DON) and went into her office. She came out of the office at 3:00 p.m. and stated she would place the set in the locked medication room. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/25/24 at 3:11 p.m., the DON stated she would keep the extra set in the medication room and stated they could also use the inner cannula if needed. The DON went into the resident's room and there was no set present at the bedside. The DON then stated there was possibly a spare set in the back storage room. She went to the room and spent approximately 1 minute trying to find the correct key to the room. Upon entering the room, she could not locate a spare set. She stated she would have to check the policy related to where the tracheostomy set should be located. At 4:05 p.m., the DON stated the facility would keep the kit at the bedside. On 6/26/24 at 7:46 a.m. Staff C, RN stated they had some tracheostomy supplies in the medication room, otherwise she would check central supply. She stated she did not know if there was anything at the bedside and stated she did not have training but the night nurse told her there was a packet for her to review. She stated she was not given direction to carry out the training prior to the start of her shift. On 6/26/24 at 8:20 a.m., Staff B, Licensed Practical Nurse (LPN) stated the spare tracheostomy set was located either in central supply or in the oxygen room, one of those two places. She stated she had never seen an extra set. A 6/26/24 Care Plan entry stated an inner cannula (the inner tube inserted into a tracheostomy tube) was hung at bedside for emergency purposes. On 6/26/24 at 8:25 a.m., an emergency tracheostomy kit hung on the wall in the residents room. The June Medication Administration Record (MAR) listed the following orders: a. A 6/7/24 order to change outer cannula (exterior tube) every 90 days with a Shiley #6 (a type of tracheostomy tube). The MAR lacked documentation of a tubing change completed from 6/7/24-6/27/24. b. A 4/17/23 order to change the inner cannula (interior tube) twice daily with a Shiley 6 millimeter(mm). The following dates lacked staff initials to indicate staff completed the change: morning entries on 6/11/24, 6/14/24, 6/15/24, 6/16/24, 6/20/24, 6/21/24 and bedtime entries on 6/15/24, 6/16/24, 6/19/24, 6/20/24, and 6/25/24. On 6/27/24 at 9:24 a.m., when queried as to what she would do if the resident's tracheostomy came out, Staff B LPN staled she always worked with Staff C and would summon her if this happened. When asked if Staff C was in the building currently, she said she was running late. She stated there was a time when the facility was out of inner cannulas. On 6/27/224 at 9:27 a.m., the DON stated staff had not changed the resident's tracheostomy set since the 6/6/24 order due to the facility not having the supplies. She said she only had the one tracheostomy kit and she did not want to use the emergency one. She stated she would order a kit. The October 2023 facility policy Respiratory System Management listed the required equipment to include a sterile tracheostomy tube. The policy described the process of how nurses should replace the tube. The policy did not address where the tracheostomy set would be located. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/27/24 at 12:10 p.m., the Nurse Consultant stated the facility educated nurses regarding how to insert a tracheostomy tube. She stated they would be able to educate all nurses except 2 today and for those not educated, they had planned to do this before their shifts. On 6/27/24 at 1:06 p.m., the DON stated emergency equipment should be readily available and staff should be trained on how to insert a tracheostomy tube.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47079 Based on observation, resident interview, and policy review, the facility failed to respond to resident call lights within 15 minutes for 1 of 3 residents reviewed (#10). The facility reported a census of 36. Findings include: On 6/24/24 at 3:36 PM, Resident #11 stated the staff does not respond within 15 minutes when the call light was used. During a continuous observation on 6/24/24 at 3:39 PM Resident #10's hallway call light was illuminated. Staff D, Certified Nursing Assistant responded to the call light on 6/24/24 at 4:05 PM. A total call response time of 26 minutes. During the observation on 6/24/24 at 4:02 PM, Resident #10 remarked staff frequently do not respond to call lights within 15 minutes. On 6/27/24 at 10:41 AM, the Administrator stated staff should respond to resident call lights within 15 minutes. A document titled Call Light Standard dated 8/2023 directed staff to answer the resident's call light as soon as practicable. Emergency call lights should be answered within one minute.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35434 Based on observation, policy review, and staff interviews, the facility failed to store and prepare food under sanitary conditions for 2 of 2 kitchen observations. The facility reported a census of 36 residents. Findings include: Observations on 6/24/24 at 2:19 p.m. during the initial kitchen tour revealed the following: a. [NAME] drips covered the floor near the coffee pot. b. White, greasy-appearing fingerprints covered the outside of the Atosa refrigerator. The vent on the interior right hand ceiling was covered with a black substance. This was located directly above beverage pitchers. A pink liquid covered the bottom left interior floor of the refrigerator. c. A yellow substance covered the inside shelves of the Avatco refrigerator. There were cheese shreds and crumbs on the bottom floor of the fridge. A towel saturated with liquid was on the bottom of the fridge and a bag of lettuce sat on the towel. Multicolored splatters covered the bottom threshold of the door. d. Heavy dust particles hung down from all parts of the fire suppression system directly above the stove burners and above a boiling pot of carrots. e. Dark brown stains on the floor and a black buildup between the floor and the wall of the dry storage room. f. Large red and brown spills on the floor of the white Frigidaire located in the back hallway. Bags of frozen corn sat next to the spills. g. Dark smudges covered the outside of the refrigerator. h. Thick black dust particles on the Air King fan which blew towards the middle of the kitchen. During a follow-up observation of the kitchen on 6/25/24 at 12:35 p.m., the above conditions remained. The observation also revealed the following: a. Upper cupboards on the right hand side of the kitchen contained plastic cups which sat upside down on blue cupboard liner. The liner was covered by multiple dark drips and stains. b. Plastic pitchers sat on the floor of the bottom cupboards on the right hand side of the kitchen. The floor of the cupboard was covered with black spots and crumbs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated facility policy Sanitation/Infection Control, stated the Dietary Manager was responsible for supervising all sanitation and housekeeping procedures within the Dietary Department. The policy stated all work and storage areas were to be clean including overhead pipes, walls, hoods, shelves, refrigerators, and freezers. The policy did not include a specific cleaning schedule. On 6/25/24 at 12:35 p.m., the Dietary Manger stated he would agree the above areas required cleaning. He stated he would look at the cleaning schedule and add some items to it. On 6/25/24 at 12:42 p.m., the Administrator stated she expected kitchen surfaces to be cleaned and sanitized.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47079 Based on record review and staff interview, the facility failed to ensure the Quality Assessment and Assurance committee was attended by the required members, including the Nursing Home Administer or representative, Director of Nursing, Medical Director representative, Infection Preventionist, and two other members of the facility's staff present on a minimum of a quarterly basis. The facility reported a census of 36 residents. Findings include: On 6/26/24 at 2:15 PM, the Administrator stated Quality Assurance Performance Improvement (QAPI) meeting sign-in sheets were not available. On 6/27/24 at 1:31 PM, a review of three QAPI folders lacked documentation of required meeting frequency and attendees. On 6/27/24 at 10:41 AM, the Regional [NAME] President of Operations stated QAPI meetings should occur quarterly and include required attendees. A document titled Quality Assurance Performance Improvement Management dated 1/2024 indicated for the QAPI Committee to successfully achieve its mission, the members should meet at least monthly and more often as needed to identify issues with respect to which QAPI activities are necessary.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, record review, staff interview, and policy review the facility failed to implement infection control practices to prevent cross contamination of invasive medical devices, failed to perform on-going Infection Control (IC) surveillance, and failed to implement measures to prevent the growth of Legionella and other opportunistic waterborne pathogens. The facility reported a census of 36 residents. Findings include: On 6/25/24 at 12:43 PM, Resident #31 wheeled himself through the dining room in his wheelchair while his indwelling catheter drainage bag dragged behind him on the floor. The drainage bag was 1/2 full of urine. At 12:47 PM, Staff E, Certified Nurse Aide (CNA) and Staff F, CNA emptied Resident #31's indwelling catheter drainage bag. They both performed hand hygiene and donned a protective gown and gloves. Staff E placed the urinal and graduated cylinder on the floor then put a paper towel under them. She held the drainage bag with her left hand and opened the drainage port with her right hand. After she emptied the drainage bag, Staff F grabbed an alcohol swab from Staff E wiped the drainage port with her right hand. At 12:52 PM, Staff F raised the drainage bag above the resident's bladder and placed the drainage bag in a dignity bag. The Minimum Data Set (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Obstructive Uropathy (blockage of the urinary tract), Renal Insufficiency, Diabetes Mellitus, and Stage 3 Chronic Kidney Disease. The Care Plan revealed the resident had an indwelling catheter and was at risk for a Urinary Tract Infection (UTI). At 12:55 PM, Staff E stated her right hand was not contaminated with urine when she emptied the drainage bag so it was ok to use the same hand to clean the port. She also stated the resident's catheter drainage bag shouldn't touch the ground and must remain below the resident's bladder. At 1:02 PM, Staff F stated the resident's drainage bag must remain below the resident's bladder. At 1:39 PM, the Director of Nursing (DON) stated she noted Staff E did not perform hand hygiene between emptying the resident's drainage bag and cleaning the drainage port and Staff F raised the drainage bag above the resident's bladder. She stated staff was educated about indwelling catheter care during the morning huddle. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24 at 10:22 AM, Staff B, Licensed Practical Nurse (LPN) and Staff C, Registered Nurse (RN) replaced Resident #15's tracheostomy inner cannula. Staff B and Staff C performed hand hygiene, donned gowns and gloves. Staff B removed the inner cannula from the resident's tracheostomy site and discarded it into a biohazard bag. She removed her gloves, performed hand hygiene and donned new gloves. She grabbed the sealed replacement cannula package from the resident's bedside table, opened it, removed the inner cannula and inserted it into the resident's tracheostomy site. The MDS dated [DATE] indicated the resident had a BIMS of 15 out of 15 which indicated completely intact cognition. It included diagnoses of acute respiratory failure with hypoxia (decreased oxygen), morbid obesity, dysphagia (difficulty swallowing), and anxiety disorder. The Care Plan indicated the resident was at risk for ineffective airway clearance related to a tracheostomy. On 6/26/24 at 4:00 PM, the facility's Infection Control surveillance data was not available for review. The Infection Preventionist (IP) and DON stated infection control surveillance, data analysis, and follow-up activity had not been completed due to administrative staff turn-over. On 6/27/24 at 7:14 AM, Staff J, Maintenance Director stated documentation to identify and prevent Legionella growth and other waterborne pathogens was not available. On 6/27/24 at 10:41 AM, the Regional [NAME] President of Operations (RVPO) stated staff should secure indwelling catheters and monitor to ensure drainage bags stay secured and do not contact the floor. She also stated staff should have changed gloves between closing the drainage port and obtaining an alcohol swab to clean it. She affirmed staff should have opened the replacement cannula packaging prior to donning clean gloves to access it. She indicated IC surveillance should be done monthly as well as audits for trending concerns. She also indicated random water temperature checks should be performed daily throughout the facility and minimally used water lines should be routinely flushed. An undated document titled Incontinence Management indicated a resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible. A document titled Infection Prevention Handwashing dated 6/2016 directed staff to perform hand hygiene after contact with contaminated items or surfaces and when initiating a clean procedure. A document titled Respiratory System Management dated 10/2023 directed staff to open the tracheostomy packaging before donning new gloves when performing tracheostomy care. A document titled Infection Surveillance dated 6/2016 indicated the facility will use a systematic method of collecting, consolidating, and analyzing data concerning the distribution and determining factors of a given disease or event. An undated document titled Legionella Water Management Plan Review directed staff to identify areas where Legionella could grow and spread, document how it will be monitored, and how often routine monitoring and testing would be completed.