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	05/21/2025

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** Based on observation, clinical record review, resident and staff interviews, the facility failed to ensure staff treated a resident with dignity and respect when they provided encouragement for a resident to take a shower for 1 of 1 residents (Resident #33) reviewed for dignity. The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #33 cognitively intact with a Brief Interview for Mental Status score of 15 out of 15. The MDS list of diagnoses included: chronic obstructive pulmonary disease exacerbation, benign prostatic hyperplasia (enlarged prostate), and urinary tract infection. The MDS indicated Resident #33 required partial/moderate assistance from staff to shower with showers. A review of a facility reported incident, dated 5/8/25 revealed a staff member called a resident a stinky [expletive], and repeatedly asked the resident why he had not paid his bill to the facility and where was he spending his money. The facility report identified the resident as Resident #33, and the staff member as the Senior Revenue Cycle Manager. During an interview on 5/13/25 at 9:29 AM, Resident #33 reported he could not recall an incident when a staff member using profanity with him. He was able to recall an incident he described as staff ganging up on him about not paying his rent and not taking a shower. Resident #33 observed to be wearing clean clothing and well groomed. During an interview on 5/14/25 at 8:34 AM, the Senior Revenue Cycle Manager (SRCM) stated a staff nurse asked her to talk to Resident #33 about taking a shower. The SRCM explained she used to work as the Social Services Designee. She denied using profanity. During an interview on 5/14/25 at 11:15 AM, the former Administrator stated it had been reported by the current Social Services Director that the SRCM (also the former Social Services Director) had used profanity with Resident #33. She explained the incident occurred on 5/6/25. The former Administrator stated the report indicated the SRCM kept bugging him [Resident #33] about taking a shower and he kept refusing. She then said she would tell people that he said f__ taking a shower (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 9:59 AM, the Social Services Director stated on 5/6/25 she and the SRCM walked into Resident #33's room and the SRCM said to the resident hey are you gonna shower today, stinky [expletive]? The Social Services Director stated she had just started working at the facility and was unsure of what to do. She stated she did tell the former Administrator the next day. During an interview on 5/15/25 at 11:10 AM, Staff M, Licensed Practical Nurse (LPN) stated on 5/6/25, she had asked the Senior Revenue Cycle Manager to talk to Resident #33 as she had been able to talk him into taking showers before. Staff M stated she was in the room, with the current Social Services Director when the SRCM talked to Resident #33 about taking a shower. Staff M denied profanity had been used.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview, the facility failed to include the use of an anticoagulant medication on the Care Plan for 1 of 3 residents (Resident #33) reviewed for Care Plans. The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #33 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS list of diagnoses included chronic obstructive pulmonary disease, benign prostatic hyperplasia (enlarged prostate), urinary tract infection. The MDS identified Resident #33 took an anticoagulant medication. The MDS indicated Resident #33 admitted to the facility on [DATE]. Review of the Physician Orders revealed an order, dated 2/10/25, revealed an order for Apixaban (generic name for Eliquis, an anticoagulant medication) Oral Tablet 5 mg (milligrams) give one tablet by mouth two times a day for blockage of blood vessel to lung by particle. Review of the May 2025 Medication Administration Record revealed Resident #33 administered apixaban 5 mg 1 tab twice daily on all days May 1, 2025 to May 14, 2025 when present in the facility. Review of the Care Plan revealed a lack of a Focus area to address the use of an anticoagulant medication. During an interview on 5/21/25 at 1:02 PM, the Director of Nursing (DON) stated she would expect the use of an anticoagulant to be included on the Care Plan. The DON stated the MDS Coordinator is responsible to updating the plan. The DON stated the current MDS Coordinator started at the facility three weeks ago so was not present when the plan was developed in February 2025. Review of the facility policy, titled Comprehensive Care Plans, effective March 2025 revealed, in part: The Comprehensive Care Plan is based on a thorough assessment that includes, but is not limited to the MDS and physician orders.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, the facility failed to update the Care Plans to reflect current to reflect current care areas and/or service needs for 2 of 2 residents (Residents #1 and Resident #8). The facility reported a census of 32 residents. Findings include: 1. Review of the Minimum Data Set (MDS) dated [DATE], identified Resident #1 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS list of diagnoses included neurogenic bladder, multiple sclerosis and anxiety disorder. Review of the Care Plan revealed a Focus area to address [Name redacted} has surgery on Bilateral ankles and is wearing casts .Created on 5/26/24. During an observation on 5/13/25 at 7;13 AM, Resident #1 in his wheelchair wearing non-skid shoes. No cast noted on either ankle/foot. During an interview on 5/21/25 at 12:12 PM, Staff M, Licensed Practical Nurse (LPN) stated Resident #1 has bilateral casts removed almost of year ago. She stated the Care Plan should no longer identify he has casts. During an interview on 5/21/25 at 1:02 PM, the Director of Nursing (DON) stated she was not the DON at the time Resident #1 had bilateral casts on his ankles. She stated if Resident #1 no longer had casts then they should not be addressed on the Care Plan. 2. Review of the MDS dated [DATE], identified Resident #8 as cognitively intact with a BIMS score of 13 out of 15. The MDS list of diagnoses included arthritis, multiple sclerosis and malnutrition. The MDS documented Resident #8 required substantial/maximal assistance with eating. The MDS indicated Resident #8 received hospice services. Review of the Care Plan, revealed a Focus area to address activities of daily living. Interventions included, in part EATING: [Name redacted] is able to: feed himself. Revision on: 4/8/24. Review of an Order Summary Report, dated 5/13/25 revealed an active order to Admit to [provider name redacted] Hospice, Order Date 4/5/25. Review of Resident #8's Care Plan revealed a lack of a Focus area and Interventions to address hospice services. A review of the facility policy titled Comprehensive Care Plans, effective date March 2025, revealed a Guidelines section which directed, in part: 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to the MDS and physician orders. Assessments of residents are ongoing and Care Plans are revised as information about the resident and resident's condition change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, the facility staff failed to provide eating assistance for 1 of 2 residents (Resident #8) reviewed for activities of daily living. The facility reported a census of 32 residents. Findings include: The Minimum Data Set (MDS) dated [DATE], identified Resident #8 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 13 out of 15. The MDS list of diagnoses included arthritis, multiple sclerosis and malnutrition. The MDS assessed Resident #8 required substantial/maximal assistance with eating, and to transfer from chair/bed-to chair, and sit to lying. The MDS documented Resident #8 received hospice services. The MDS documented Resident #8 weighed 138 pounds. Review of an Order Summary Report, dated 5/13/25 revealed an active order to Admit to [provider name redacted] Hospice, Order Date 4/5/25. Review of the Care Plan, Revision on 1/9/25 revealed a Focus area to address I have an ADL (activities of daily living) self-care performance deficit r/t Musculoskeletal impairment. [Name redacted] is at risk for declines in late loss ADL's (bed mobility). Interventions included, in part: EATING: [Name redacted] is able to: feed himself. Revision on: 4/8/24. Review of the Vitals/Weights in the electronic health record revealed Resident #8 weighed 106 pounds on 5/2/25. Observations of the meal service provided to Resident #8 in his room revealed: a. On 5/12/25 at 12:25 PM, Staff P, Certified Nursing Assistant (CNA) delivered a lunch tray to Resident #8. Resident #8 in bed sleeping. Staff P set tray on the over the bed table and left without letting the resident know his meal had been served. b. On 5/14/25 at 12:29 PM, Staff N, CNA delivered a lunch tray to Resident #8. She placed the tray on the over the bed table. Staff N then exited the room without offering the resident assistance. Resident #8 attempted to reposition to his side and reach over the side rail to eat his food. The call light was out of reach on the nightstand near the foot of his bed. During an interview on 5/15/25 at 9:47 AM, Staff K, Hospice Registered Nurse stated she had been aware of Resident #8 weight lose prior to starting hospice and has continued to lose weight. Staff K stated his intake has been poor, and he has refused appetite stimulants. Staff K stated the weight lose is anticipated. During an interview on 5/15/25 at 11:10 AM, Staff M, Licensed Practical Nurse stated staff should assist Resident #8 to sit up for his meal. She stated he will eat lying on his side. Staff M stated that sometimes Resident #8 requires assistance with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 7:21 AM, Staff E, CNA stated that staff need to make sure Resident #8 sits up with the head of his bed up and help him eat. She stated if he refused to eat what is served she would get him something different to eat. She stated if he continued to refuse she would inform the nurse. During an interview on 5/21/25 at 10:15 AM, Staff I, CNA stated Resident #8 should be positioned in bed for meals with the head of his bed up. She stated Resident #8 requires supervision while eating. During an interview on 5/21/25 at 1:02 PM, the Director of Nursing stated she would expect staff to assist Resident #8 to sit up and stay with him during the meal to assist him, when he wants to eat. Review of the facility policy titled Dining Environment, approved October 2024, revealed a Guidelines section which directed, in part: 8. Nursing Services Personnel will help to seat and position residents and to identify factors that might adversely affect food intake.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to assess a resident, with a known history of substance abuse, after they returned to the facility under the influence for 1 of 1 resident (Resident #33) reviewed. The facility reported a census of 32 residents. Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #33 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS list of diagnoses included chronic obstructive pulmonary disease, benign prostatic hyperplasia (enlarged prostate), urinary tract infection. The MDS indicated Resident #33 admitted to the facility on [DATE]. Review of an admission Summary entered on 2/10/25 revealed, in part .Arrived to ED (emergency room) on 2/4/25 unresponsive, resident reported to ED to have used methamphetamines' and ecstasy prior to unresponsive episode .Resident Hx (history): .alcohol abuse, substance abuse .Discharge summary faxed to [provider name redacted], aware of admission. Review of the Care Plan, Date Initiated: 4/2/25 revealed a Focus area to address Impaired Coping: Hospice status & Known Substance Use. Interventions included, in part: a. 2/28/25: Found intoxicated in his room with a bottle of vodka. Date Initiated: 4/7/25. b. 4/16/25: Resident had water bottle with vodka in it at bedside and empty syringe fell from chair in dining room matching syringes found in room substance found in syringe baggy and turned over to police. Date Initiated: 4/16/25. c. 4/4/25: Leaving facility without signing out and returning intoxicated. Date Initiated: 4/7/25. Review of the electronic health record revealed: a. Order Note entered on 4/4/25 at 6:15 PM, revealed New orders from St. Croix Hospice to place all narcotics on hold in system for 72 hours d/t resident leaving the facility without signing out and past incident. Resident notified of new orders and not happy. This DON also educated resident & ride on the procedure of signing out each time he is leaving the facility. b. Incident Note entered on 4/16/25 at 1:13 PM, revealed Multiple staff and resident approached this nurse with concerns for resident stating they feel he is under the influence of an unknown substance d/t appearance and strange behavior. This nurse observed resident from nurse station before going into residents room with CMA (Certified Medication Assistant) [initials redacted] where a bottle of water was seen on bed side table a little over half full. Both this nurse and CMA smelled the contents in water bottle, smelling alcohol. This nurse and CMA informed DON (Director of Nursing) and administrator of reported and finding. 1/1 monitoring in on-going with resident. c. Lab Note entered on 4/16/25 at 13:32, revealed UA results received, abnormal results as follow: Opiates - Detected Amphetamines - Detected Benzos - Detected Clarity - Cloudy Ketones 15 Blood - Trace Nitrate - Pos WBC - >50 H RBC - 5 H WBC Clumps - Present Faxed to [provider name redacted] No N.O (new orders) at this time. Resident informed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Health Status Note entered on 4/16/25 at 2:54 PM, revealed EMS (emergency medical services) arrived to facility to transport resident to ED fir evaluation. Review of the electronic health record revealed a lack of nursing assessment completed on 4/4/25 and 4/16/25 after the resident returned to the facility and suspected of having been under the influence. During an interview on 5/19/25 at 12:26 PM, the DON stated she if a resident with a known history of substance use returned to the facility and staff suspected they were under the influence for an assessment to be completed. She stated she would expect this to include vital signs, respiratory effort, eyes, pupils dilated, overall demeanor. She would expect them to check on the resident every 15 minutes throughout the night, or until there was an order for the resident to go to the emergency room for evaluation and treatment. Review of the facility policy titled Change in a Resident's Condition or Status, approved October 2024, revealed a Policy Interpretation and Implementation section which directed, in part: 3. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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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** Based on observations, clinical record review, facility policy review, resident and staff interviews, the facility failed to ensure the safety of residents when a resident with an oxygen tank secured to a wheelchair sat in the designated smoking area with other residents engaged in smoking a lit cigarette, and then staff physically carried the oxygen tank from the smoking area through the facility to the oxygen storage area for 1 of 6 (Resident #23) residents reviewed for accidents and hazards. The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #23 cognitively intact with a Brief Interview for Mental Status score of 15 out of 15. The MDS list of diagnoses included: which indicated intact cognition. The assessment identified the resident utilized a walker and a wheelchair for mobility. The MDS revealed Resident #23 had shortness of breath or trouble breathing when lying flat and utilized non-invasive mechanical ventilator. Review of the May 2025 Medication Administration Record revealed O2 (oxygen) per nasal cannula (2-4 L [per minute, the rate at which oxygen is to be delivered] with exertion, PRN (as needed). Maintain sats (blood oxygen saturation) > (above) 86% as needed for maintain sats > 86%. Start Date: 10/30/24. Review of undated document titled, Smoking Residents revealed 9 residents in the facility smoked. Resident #23 identified on the list as a smoker. During an observation on 5/12/25 at 1:25 PM, a sign posted on the patio door leading to the designated smoking area listed smoking times of 8:30 AM, 1:30 PM, and 7:00 PM. During an observation on 5/12/25 at 1:27 PM, Resident #23 self-propelled her wheelchair to the designated smoking area. A portable oxygen tank noted to be secured to the back of Resident #23 wheelchair. Five other residents also present in the designated smoking area. At 1:33 PM, the Director of Nursing (DON) brought outside a plastic tote of smoking supplies and handed out cigarettes to the residents, with the exception of Resident #23. At 1:36 PM, the DON assisted the five residents with lighting the cigarettes. Resident #23 remained outside, sitting in her wheelchair approximately two feet from another resident while they smoked a cigarette. Resident #23's oxygen tank not in use during this observation. At approximately 1:38 PM, the State Agency notified the Interim Administrator of Resident #23 sitting outside, with an oxygen tank secured to her wheelchair while other residents are smoking. The Interim Administrator went to the designated smoking area and spoke to the DON. The DON spoke with Resident #23 and then removed the oxygen tank from the back of the resident's wheelchair and handed the unsecured oxygen tank to the Interim Administrator. The oxygen tank meter observed and indicated the tank on empty. The Interim Administrator confirmed the tank on empty. The Interim Administrator then physically carried the unsecured oxygen tank to the facilities oxygen room. (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 5/13/25 at 9:00 AM, Resident #23 stated she had screwed up the other day and had an oxygen tank on her wheelchair when she went to out [to the smoking area]. Resident #23 stated she had not realized the oxygen tank was on back of wheelchair as it was empty and she planned to give the tank to the nursing staff. Resident #23 stated she would typically not have an oxygen tank on the back of her wheelchair or be outside during designated smoking times. Resident #23 stated she no longer smoked. During an interview on 5/15/25 at 11:09 AM, Staff M, Licensed Practical Nurse (LPN), stated Resident #23 does not often go outside during smoking times, and she no longer smoked. Staff M reported Resident #23's oxygen order was for as needed use, when oxygen saturations went below normal levels. Staff M revealed that Resident #23 would typically keep an oxygen tank on back of wheelchair and notify nursing staff when tank was empty or she needed a new tank. When queried, Staff M reported she would remove the oxygen tank if seen near residents smoking and stated that even if oxygen tank was empty, it may still be flammable due to chance for residual oxygen in tank. During an interview on 5/21/25 at 10:15 AM, Staff I, CNA, recalled one instance in the past one to two months, unable to recall a date, in which Resident #23 was going outside to the smoking area and resident's portable oxygen tank had been on back of the wheelchair. Staff I reported she removed the tank and left it inside the facility while Resident #23 went outside to visit with other residents during a smoking time. During an interview on 5/21/25 at 1:11 PM, the Director of Nursing (DON), stated Resident #23 did not often utilize oxygen unless she had an asthmatic episode. The DON stated that on 5/12/25 she had been pulled to supervise the 1:30 PM smoking time and didn't see or realize Resident #23 had been outside until the Interim Administrator came outside to notify her of the oxygen tank. When queried, DON reported she would not allow Resident #23 to go outside during smoking times with an oxygen tank on her wheelchair or would remove the portable oxygen tank before the resident went outside. DON explained that even if tank was empty, an oxygen tank would not be safe around residents smoking due to tank being flammable or had the potential to blow up. Review of the undated facility policy, titled Smoking Policy included a Policy statement which declared, in part: It is the policy of this facility to comply with all federal and state regulations and implement proper systems to ensure that all residents and staff are monitored for compliance. The facility policy titled, Oxygen Administrator, effective 10/2024, revealed a Purpose statement which declared The purpose of this procedure is to provide guidelines for safe oxygen administration. The Steps in the Procedure section directed, in part: 4. Remove all potentially flammable items (e.g., lotions, oils, alcohol, smoking articles, petroleum jelly products, etc) from the immediate area where oxygen is to be administered. The Oxygen Administration policy did not address safe transport of oxygen tanks.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record review, and facility policy review, the facility failed to identify a weight loss, notify the physician and ensure Registered Dietician follow up for 1 of 3 (Resident #9) residents identified for weight loss. The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set (MDS) Assessment, dated 3/12/25, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated a moderate cognitive impairment. The MDS list of diagnoses included cerebrovascular accident (a stroke), diabetes mellitus, contracture of left forearm and left hand, and gastro-esophageal reflux disease (GERD). The MDS indicated Resident #9 had one sided impairment of his upper and lower extremity, utilized wheelchair for mobility, and required set up assistance to eat. The MDS documented a weight of 222 pounds, with no weight loss of gain within the last six months. Review of the Care Plan, Date Initiated: 10/17/24 revealed a Focus area to address I require assistance with ADL's (activities of daily living) r/t (related to) Impaired balance, Limited Mobility and Stroke. Interventions included, in part: EATING: The resident requires assistance by staff to eat. Date Initiated: 10/17/24. Review of the Weight Summary in the electronic health record revealed a weight of 222.4 Lbs (pounds) on 3/12/25, and 207.0 Lbs on 4/1/25, 4/2/25, and 4/4/25. Review of the electronic health record did not reveal notification of the physician regarding the weight loss, or interventions. Review of a N Adv - Long Term Care Evaluation entered on 4/2/25 at 9:37 AM revealed, in part: Vitals: 207 pounds by mechanical lift. Nutrition: Taking nutrition and hydration orally. No complaints of thirst. No signs/symptoms of a swallowing disorder. Mucous membranes moist. Review of Nutrition/Dietary Note entered on 5/10/25 at 8:37 AM revealed He triggered for a significant weight loss at 6.9% (15.4 lbs) in 30 days and 9.7% (22.2 lbs) in 90 days. Etiology of significant weight loss is incorrect weight for April 2025. Weight: His current weight of 207.0 lbs (4 April 2025), 222.4 lbs (12 March 2025), 229.4 (2 January 2025) and 228.8 lbs (2 October 2025). He has lost 15.4 lbs (6.9%) in 30 days, 22.2 lbs (9.7%) in 90 days and 21.8 lbs. (9.5%) in 180 days. Question his April 2025. His BMI (body mass index a calculated measure of weight relative to height) is 28.9 kg/m2 (kilograms/meters squared) which is in the overweight class. His IBWR (ideal body weight range) is 155-189 lbs. Adjusted for males >[AGE] years old. Diet: He is on a regular diet, regular texture with thin consistency liquids. His po (oral intake) is 51 - 100% of meals. He dines independently with occasional supervision .Recommendations: No recommendations at this time. Continue to monitor po intake, weight, and nutritional parameters and refer to RD (registered dietician) prn (as needed). (continued on next page)

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	05/21/2025

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/13/25 at 11:38 AM, Resident #9 ate lunch in the dining room. The resident sat in high back wheelchair, with the right side of his body parallel to the table. The wheelchair tilted back into a semi-reclined position. Resident #9's head and neck flexed upwards towards the ceiling, with no support. Resident #9 stretched his right arm out straight to reach the plate on dining room table and feed him self-lunch. Staff present in the dining room did not intervene to reposition, or provide the resident assistance. During an observation on 5/14/25 at 11:44 AM, Resident #9 sat in a geri chair, with a rolled towel behind his head for positioning. Staff placed a tray in front of Resident #9 so his meal sat in front of him rather to the side as on 5/13/25. Resident #9 fed himself. Staff present in the dining room did not provide the resident assistance. During an interview on 5/14/25 at 1:40 PM, the Registered Dietitian (RD) confirmed being aware of Resident #9's weight loss of 15.4 pounds since April 2025. The RD stated she believed April's weight to be incorrect. She stated she should have asked the facility to reweigh Resident #9 in April. The RD stated she had visited the facility on 5/09/25 and did not put in to place any weight loss interventions for Resident #9 until a reweight from April had been recorded. Review of a Nutrition/Dietary Note, completed by the RD, entered on 5/14/25 at 10:03 PM, revealed that Resident #9 had been reweighed on this date with same weight as previous month which triggered for 30-day significant weight change. The RD recommendation for Resident #9 to receive Mighty Shakes twice per day with the goal for weight to remain within 3% of current weight. An email sent by the Director of Nursing (DON) on 5/15/25 at 12:48 PM revealed the facility recalibrated the mechanical lift scale to ensure accuracy and Resident #9's re-weight after the calibration was 204.6 pounds. During an interview on 5/15/25 at 11:09 AM, Staff M, Licensed Practical Nurse (LPN), stated Resident #9 preferred to sit in a reclined position and often refused to sit upright at meals. Staff M stated Resident #9 had oral secretions and occasional coughing during meals but had no choking, aspiration, or pneumonia. Staff M reported that Resident #9 would refuse supper meals one to two times per week due to fatigue and request to go to bed early. During an interview on 5/21/25 at 10:15 AM, Staff I, Certified Nursing Assistant (CNA), stated Resident #9 had secretions and coughed when he smoked, but during meals. Staff I stated Resident #9 would sometimes go to bed in the evening and not eat supper depending on if he liked the meal. During an interview on 5/21/25 at 1:11 PM, the DON stated she would expect nursing staff to identify and follow up if a resident lost weight to ensure accuracy. She stated she would expect interventions to be put in place when a weight loss is identified. Review of the facility policy, titled Weight Assessment and Intervention, effective 10/2024, revealed a Policy statement which declared The Interdisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss or gain. The Guidelines, Weight Assessment section directed, in part: (continued on next page)

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Aspire of Muscatine	2002 Cedar Street Muscatine, IA 52761

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Re-weights will be obtained as needed within 24 hours and recorded per community protocol. If the weight change is significant (as identified in point #5) the RD and MD (medical doctor) will be notified. 5. The threshold for significant unplanned and undesired weight changes will be based on the following criteria a. 1 month - 5% weight change is significant; greater than 5% is severe.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview the facility failed to provide oxygen therapy in accordance with professional standards as evidenced by a lack of a physician's order to direct the use of oxygen, and the failure to include oxygen therapy on the Care Plan for 1 of 1 resident (Resident #20). The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set, dated [DATE], revealed Resident #20 a Brief Interview for Mental Status score of 14 out of 15, which indicated intact cognition. The MDS list of diagnoses included Guillain-Barre Syndrome, anemia, and obesity. The MDS documented Resident #20 required oxygen therapy while a resident. During an observation on 5/13/25 at 10:20 AM, Resident #20 wore a nasal cannula connected to an oxygen concentrator with the flow set at 4 liters of oxygen per minute. Review of the May 2025 Mediation Administration Record revealed an order, Start Date 5/18/24 to Check O2 (oxygen) sat (saturation, a measure to indicate the oxygenation of blood) every shift, apply O2 to keep sat above 90%. Every shift for low O2 sats. On 5/21/15 a review of Medication Review Reported revealed a lack of an order to direct the amount of oxygen [typical ordered by liters per minute] to deliver, the method [such as a nasal cannula, or face mask] for delivery of the oxygen, and if oxygen therapy to be delivered as needed or continuous. Review of the Care Plan revealed a lack of a Focus area and Interventions to address Resident #20 required oxygen therapy. During an interview on 5/21/25 at 12:12 PM, Staff M, Licensed Practical Nurse (LPN), recalled that Resident #20 has an order for oxygen since last year when she had been out to the hospital. During an interview on 5/21/25 at 1:11 PM, the Director of Nursing (DON) revealed the expectation that oxygen usage would be reflected by a Physician's order and would be included in the resident's Care Plan.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and facility policy review, the facility failed to notify the physician of changes in condition for 2 of 3 resident (#8 and #9) reviewed for physician notification. The facility reported a census of 32 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment, dated 3/12/25, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment. The MDS revealed no weight loss or gain identified during the assessment period with weight recorded as 222 pounds. Diagnoses included cerebrovascular accident (stroke), diabetes mellitus, contracture of left forearm and left hand, and muscle wasting of multiple sites. Review of facility recorded weights revealed on 3/12/25, Resident #9 weighed 222.4 pounds and on 4/01/25, 4/02/25, and 4/04/25, Resident #9 weighed 207 pounds. Documented weights indicated Resident #9 had a weight loss of 15.4 pounds (6.92% loss of body weight) in one month. Review of Nutrition/Dietary Note entered on 5/10/25 at 8:37 AM revealed He triggered for a significant weight loss at 6.9% (15.4 lbs) in 30 days and 9.7% (22.2 lbs) in 90 days. Etiology of significant weight loss is incorrect weight for April 2025. Weight: His current weight of 207.0 lbs (4 April 2025), 222.4 lbs (12 March 2025), 229.4 (2 January 2025) and 228.8 lbs (2 October 2025). He has lost 15.4 lbs (6.9%) in 30 days, 22.2 lbs (9.7%) in 90 days and 21.8 lbs. (9.5%) in 180 days. Question his April 2025. His BMI (body mass index a calculated measure of weight relative to height) is 28.9 kg/m2 (kilograms/meters squared) which is in the overweight class. His IBWR (ideal body weight range) is 155-189 lbs. Adjusted for males >[AGE] years old. Diet: He is on a regular diet, regular texture with thin consistency liquids. His po (oral intake) is 51 - 100% of meals. He dines independently with occasional supervision .Recommendations: No recommendations at this time. Continue to monitor po intake, weight, and nutritional parameters and refer to RD (registered dietician) prn (as needed). Review of the electronic health record revealed a lack of physician notification of Resident #9 weight loss. During an interview on 5/21/25 at 1:11 PM, the Director of Nursing stated it is expected the physician would be notified of resident's significant weight loss. Review of the facility policy, titled Weight Assessment and Intervention, effective 10/2024, revealed a Policy statement which declared The Interdisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss or gain. The Guidelines, Weight Assessment section directed, in part: 3. Re-weights will be obtained as needed within 24 hours and recorded per community protocol. If the weight change is significant (as identified in point #5) the RD and MD (medical doctor) will be notified. (continued on next page)

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	165585	A. Building B. Wing	05/21/2025

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The threshold for significant unplanned and undesired weight changes will be based on the following criteria a. 1 month - 5% weight change is significant; greater than 5% is severe.

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	165585	A. Building B. Wing	05/21/2025

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, the facility failed to provide training to the staff to address behavioral health care needs for 1 of 1 resident (Resident #33) with a substance use disorder, The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #33 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS list of diagnoses included chronic obstructive pulmonary disease, benign prostatic hyperplasia (enlarged prostate), urinary tract infection. The MDS indicated Resident #33 admitted to the facility on [DATE]. Review of an admission Summary entered on 2/10/25 revealed, in part .Arrived to ED (emergency room) on 2/4/25 unresponsive, resident reported to ED to have used methamphetamines' and ecstasy prior to unresponsive episode .Resident Hx (history): .alcohol abuse, substance abuse .Discharge summary faxed to [provider name redacted], aware of admission. Review of the Care Plan, Date Initiated: 4/2/25 revealed a Focus area to address Impaired Coping: Hospice status & Known Substance Use. Interventions included, in part: a. 2/28/25: Found intoxicated in his room with a bottle of vodka. Date Initiated: 4/7/25. b. 4/16/25: Resident had water bottle with vodka in it at bedside and empty syringe fell from chair in dining room matching syringes found in room substance found in syringe baggy and turned over to police. Date Initiated: 4/16/25. c. 4/4/25: Leaving facility without signing out and returning intoxicated. Date Initiated: 4/7/25. d. Determine Resident's coping methods. Date Initiated: 4/7/25. e. Encourage participation in self-calming behaviors such as breathing exercises, meditation or guided imagery. Date Initiated: 4/7/25. During an interview on 5/21/25 at 10:15 AM, Staff I, Certified Nursing Assistant (CNA) stated when a resident who has a history of drug/alcohol abuse, the type kind of behavior she would look for that might alert you that the resident might be under the influence would be slurred speech, extremely tired, or agitation, tick with the mouth, and she would report this to a nurse. Staff I stated she did not remember receiving any type of training on how to deal with residents who appear to be under the influence of drugs or alcohol. During an interview on 5/21/25 at 11:38 AM, Staff Q, CNA when asked about Resident #33 Care Plan stated when she sees that kind of behavior that might indicate he was under the influence of drugs/alcohol she does not know what to do. Staff Q stated she did not receive any training from the facility regarding how to deal with that type of situation. (continued on next page)

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	165585	A. Building B. Wing	05/21/2025

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 1:02 PM, the Director of Nursing reported she could not recall that the staff had been provided education on what to do if a resident with substance abuse history has behaviors of being under the influence and reported the facility did not have a policy to address resident substance abuse.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, kitchen record review and staff interviews, the facility failed to ensure kitchen staff were trained and able to perform their job duties as required. The facility reported a census of 32 residents. Findings include: During an observation on 5/13/2025 at 10:52 AM, the [NAME] prepared a pureed meal for one resident with a pureed diet order. The [NAME] pureed a peanut butter and jelly sandwich with milk added. When asked, the [NAME] did not know how much milk was added but estimated a quarter of a cup. The [NAME] then shared that the puree mixture was too runny and added another peanut butter and jelly sandwich. The [NAME] continued to puree until she believed it was the desired consistency. When asked what else would be pureed for the meal, the [NAME] stated the resident doesn't like very many things and will usually only eat peanut butter and jelly sandwiches. The [NAME] stated sometimes she will give the resident some ice cream or pudding but the resident won't eat the other menu items. During an interview on 05/14/25 at 1:45 PM the Dietary Manager (DM) stated he was not sure what training and skill competencies the [NAME] had, but she had worked at the facility for long time. He stated most of the kitchen staff had not worked at the facility for very long. He stated the kitchen staff were not ServeSafe certified. When asked about the puree process observed on 5/13/25, the Dietary Manager stated he did not necessarily watch the cook but from what he has observed the staff did a pretty good job. The Dietary Manager was unable to name the desired consistency but indicated it should be similar to the consistency of apple sauce. The DM stated the menu binders with the meal recipes include the portion sizes which he stated is what the facility follows. The DM stated the kitchen staff does not use the puree chart posted on the wall for portion/scoop sizes. The Dietary Manager was then asked about nutrition and substitutions. The DM stated most of the time if a resident doesn't like the meal they ask for something else. The DM stated the facility will typically have left overs and that can be headed up for a resident. The DM stated the facility does not have an alternative menu but they always have some sort of soup and sandwich they can make the resident. The Dietary Manager stated it is expectation staff make several attempts to offer the resident something else if they don't want what is on the menu. When asked about nutritional requirements the DM stated the facility would start making an alternative vegetable as they hadn't been doing that. The DM then shared, residents complain they have fish too often so they would be offered a soup or sandwich. The DM stated food substitutions are logged and the dietician signs off of them every other week when they are at the facility. Review of the substitution list revealed two entries for in the last month, neither signed off by the dietician. When queried about the staff not taking and recording food temperatures, the Dietary Manager stated staff would need additional training. The DM stated he did not know who was in charge of tracking resident intake. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/25 at 09:01 AM, the Registered Dietician (RD) stated she had worked with staff on the puree process but had not watched them do the puree process for a while. She stated she knew the facility had the puree process chart up and they followed that. She advised she had not worked side by side with the Dietary Manager. When observations regarding the puree process, lack of food temperatures, lack of an alternative menu were shared with the RD she advised those practices would not meet her expectations. She advised the kitchen staff should contact her if they had to make a substitution, but rarely do. The RD stated if there is a substitution she would also sign off on it when she is at the facility. The RD advised either the dietary staff or nursing staff track resident food intake and she would receive a notice if there were a significant change or concern. When queried the RD advised she had not seen evidence of insects or rodents but it would be concerning to her if there were any roach or insect traps on the counters. It is the RD's expectation that there would not be any insect or rodent traps in any area where there is food. During an interview on 05/20/25 at 08:50 AM, the [NAME] stated she may have not done the puree correctly (observed on 5/13/25), but she was nervous. She stated she should have used the puree chart and measured her portions. Instead of adding another peanut butter and jelly sandwich she should have used the thickener. The [NAME] stated she should offer more alternatives if a resident does not like the meal. During an interview on 5/21/25 at 02:05 PM, after learning of observations of the food service and kitchen processes, and interviews with the kitchen staff, the Director of Nursing (DON) and the Interim Administrator stated they have much higher expectations for the kitchen staff. They stated an audit will be completed and all kitchen staff will be required to have additional training. All policies and procedures are expected to be followed. Upon request the facility did not submit a policy regarding kitchen staff training and competency.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on kitchen record review, facility policy review and staff and resident interviews, the facility failed to ensure the dietician approved menu is followed and adequate quantities of substitutions are available to all residents. The facility reported a census of 32 residents. Findings include: During an interview on 5/13/2025 at 10:52 AM, the [NAME] stated when she is making the lunch meal sometimes she does not have everything she needs and has to make substitutions. She explained it is usually the vegetable or fruit she has to substitute. The cook stated when it is a minor substitution she does not need permission, but when it is something that isn't similar she is expected to contact the Dietary Manager for approval. The [NAME] stated once the substitution is approved it is then written on the substitution log and the Registered Dietician will sign off when she is at the facility. The [NAME] shared that the residents don't like noodles back to back so recently instead of the beef macaroni casserole she served goulash. The [NAME] shared a lot of times if a resident does not like something they are having or doesn't want the fruit or vegetables, they want more of the main course. The [NAME] stated this is provided if they have enough left after the first serving. During an interview on 05/19/25 at 09:01 AM the Registered Dietician stated she had not worked side by side with the Dietary Manager. She advised the kitchen staff had not contacted her if they had to make a substitution. If there is a substitution she would also sign off on it when she is at the facility. The RD advised it is her expectation that the planned menus are followed to meet the resident's nutritional needs. During an interview on 05/20/25 at 12:40 PM, two residents stated they there were not happy with the food. The residents stated there not very many food options or choices. One resident stated he did not feel the portions were big enough and the kitchen should hire someone that knows how to cook. During an interview on 05/21/25 at 02:05 PM the Director of Nursing (DON) and the Interim Administrator stated it is their expectation that the menus are followed. The facility provided a policy titled, Resident Food Preferences, effective October 2024, revealed a Guidelines section which directed, in part: 7. The Food Services Department will offer food substitutes for individuals who do not want to eat the primary meal. Substitutions offered will be of similar nutritive value.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interviews, the facility failed to provide food per the resident's preferences for1 of 3 residents reviewed (Resident #29). The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set (MDS) dated [DATE] identified Resident #29 as cognitively intact with a Brief Interview for Mental Status score of 15 out of 15. During an interview on 5/15/25 at 8:00 AM, Resident #29 stated he was served rice and corn yesterday and he does not like these two food items. He stated he to the Dietary Manager before about this and if he had to talk to him about this again, he would not eat their food again. He was getting tired of getting served food he did not like. The resident stated the last time he saw the dietitian was last year. Review of the Resident #29 meal tray card identified he did not like rice and corn. During an interview on 5/19/25 at 1:08 PM, the Registered Dietitian stated she was not aware that Resident #29 did not like rice and corn. She stated when she has spoken to Resident #29 he stated he was not getting enough carbohydrates. During an on 5/21/25 at 7:21 AM, Staff E, Certified Nursing Assistant (CNA) stated Resident #29 had complained to her that he does not like corn or rice when it is served to him. Staff E stated when resident has reported he does not like a certain food, which is identified on the tray card, the staff should return the tray to the kitchen and get him something he likes. Review of the facility policy titled Resident Food Preferences, effective October 2024 revealed a Guidelines section which directed, in part: 1. Upon the resident's admission the Food Service Manager, Dietitian, or nursing staff will review the resident's likes and dislikes with the resident or family member, if the resident is unable to communicate his/her needs. 6. The Food Service Manager, Dietitian, or nursing staff will visit residents periodically to determine if revisions are needed regarding food preferences. The nursing staff will inform the kitchen about resident requests.

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	05/21/2025

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

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F 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. Based on observations, facility policy review and staff interviews, the facility failed to safe thawing practices and use of insect traps in an attempt to minimize the potential for food borne illness. The facility reported a census of 32. Findings include: During an initial kitchen tour on 5/12/25 at approximately 12:30 PM, the following conditions were revealed: a. A package of raw hamburger thawing in the refrigerator next to a box of lettuce. The hamburger was not in a drip pan and had been placed directly on the refrigerator rack. b. A insect trap placed on the kitchen counter work space. During an observation of the noon meal service in the kitchen on 5/13/25 at 11:46 AM, two insect traps visible on the counter behind the coffee pots. During an interview on 5/13/25 at 11:46 AM, the [NAME] stated she had taken out the raw hamburger out of the refrigerator to use. When queried about the location of the hamburger thawing in the refrigerator on 5/12/25, she stated she did not think it was an issue because the hamburger was sealed and the lettuce box was closed. During an interview on 5/14/25 at 1:45 PM, the Dietary Manager (DM) stated he was not aware of the hamburger being next to the lettuce. He reported the hamburger should have been in some sort of a pan and should not have been near the lettuce due to the possibility of cross contamination. When queried about the insect traps the DM advised he didn't realize they were there. He also advised they have pest control come into the facility but he was not aware of any current issues. During an interview on 05/19/25 at 09:01 AM, the facility Registered Dietician stated she had not seen evidence of insects or rodents but it would be concerning to her if there were any insect traps on the counters. She stated it is her expectation that insect or rodent traps are not in an area where there is food being prepared. Review of the facility policy titled Food Preparation and Service, effective October 2024, revealed a Thawing Frozen Food section which directed, in part: 1. Foods will not be thawed at room temperature. Thawing procedures include: a. Thawing in the refrigerator in a drip-proof container; Review of the facility policy titled Pest Control, effective October 2024, did not address the use of insect traps in the kitchen.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of the CMS CASPER (Certification and Survey Provider Enhanced Reporting) report, facility policy review and staff interviews, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address and prevent repeated deficiencies in three required areas. The facility reported a census of 32. Findings include: A review of the CMS CASPER (Certification and Survey Provider Enhanced Reporting) Report Provider History Profile revealed the facility has had repeated deficiencies in the following areas: a. Food Procurement, Store/Prepare/Serve: F812 cited on surveys that occurred April 2023, June 2024 and the current survey. b. Quality Improvement Program: F868 cited on surveys that occurred April 2023, June 2024 and the current survey. c. Infection Prevention & Control: F880 cited on surveys that occurred April 2023, June 2024 and the current survey. During an interview on 05/21/25 at 02:05 PM the Director of Nursing (DON) and the Interim Administrator stated they have much higher expectations for the facility and they are working on improvements. They explained the facility had high staff turnover but continue to want the facility to be the best that it can be. They stated additional staff training has been provided, and they expect all policies and procedures are followed. Review of the facility policy titled Quality Assessment and Performance Improvement Plan and Program, effective August 2024 revealed a Policy statement which declared The facility shall develop, implement, and maintain an effective, comprehensive, data driven Quality Assessment and Performance Improvement program (QAPI) that focuses on indicators of the outcomes of care and quality of life. The Guidelines section, included the Purpose of the QAPI Program, which included: a. Ensuring care delivery systems function consistently, accurately, and incorporate current and evidenced based practice standards when available; b. Preventing deviation from care processes, to the extent possible; c. Identifying issues and concerns with facility systems, as well as identifying opportunities for improvement; and d. Developing and implementing plans to correct and/or improve identified areas.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, and staff interviews, the facility failed to implement infection control practices to minimize the risk of infections due to a failure to change gloves during wound care for 1 of 2 residents (Resident #8) reviewed for wounds, failure to keep a urinary catheter bag and tubing off the floor and follow Enhanced Barrier Precautions when draining a catheter bag for 1 of 1 resident (Resident #29) reviewed for catheter care. The facility reported a census of 32 residents. Findings include: 1. Review of the Minimum Data Set (MDS) dated [DATE], identified Resident #8 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 13 out of 15. The MDS list of diagnoses included arthritis, multiple sclerosis and malnutrition. The MDS assessed Resident #8 dependent on staff for toileting and bathe/showers, and required substantial/maximal assistance with eating, oral hygiene, dressing, personal hygiene and repositioning. The MDS documented Resident #8 with two Stage 2 pressure ulcers. Review the Order Summary Report dated 5/13/25, revealed an order to cleanse wound with soap and water, pat dry, apply zinc oxide to open area and over with Optifoam (type of wound dressing) every night shift for wound care. Start Date: 4/18/25 Review of the Care Plan, Date Initiated: 4/5/25, revealed a Focus area to address I have actual impairments to skin r/t (related to) lack of nutritional intake. Interventions included, in part: Left Buttock - cleanse with soap & water, apply zinc oxide, & cover with optifoam. Date Initiated: 4/5/25. During an observation of wound care on 5/13/25 at 9:40 AM, Staff B, Registered Nurse washed her hands, donned gloves and cleansed the wound going from the inside to the outside of the wound bed. Wearing the same gloves, Staff B then applied zinc oxide and the optifoam dressing to the wound. During an interview on 5/21/25 at 1:02 PM, the Director of Nursing (DON) stated she would expect nursing staff to remove gloves and wash their hands after cleansing a wound, then apply new gloves prior to applying a treatment and new dressing. Review of the facility policy titled Wound Care Guidelines, approved April 2024 included a Purpose statement which declared The purpose of this procedure is to provide guidelines for the care of wounds and to promote healing. The Steps in the Procedure section directed, in part: 4. Wash and dry your hands thoroughly. 6. Apply disposable gloves. Loosen tape and remove dressing. 7. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 8. Put on disposable gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. Wear disposable gloves when physically touching the wound or holding a moist surface over the wound. 2. Review of the MDS dated [DATE], identified Resident #29 as cognitively intact with a BIMS score of 15 out of 15. The MDS list of diagnoses included heart failure, neurogenic bladder (lack of control due to nerve damage) and diabetes mellitus. The MDS documented Resident #29 utilized an indwelling urinary catheter. Review of the Care Plan, Date initiated: 6/13/24, revealed a Focus area to address [Name redacted] is at risk for infection r/t (related to) CAUTI (catheter-associated urinary tract infection) d/t (due to) res (resident) places catheter bag above bladder and constantly needs reminders to not touch drainage system. [Name redacted] drags the bag on the floor at times. [Name redacted] can be incompliant with his drainage bag, staff often encourage resident to keep it in its designated area. Interventions included, in part: a. Advanced barrier precautions d/t catheter with all catheter cares using gown and gloves and draining while in room. Date Initiated: 6/13/24 b. Staff to intervene that catheter bag is not dragging on floor. Date Initiated: 6/13/24 During observations on 5/13/24 the following noted regarding Resident #29 catheter bag & tubing placement and care: a. At 10:40 AM, observed sign posted on Resident #29 room door which directed Enhanced Barrier Precautions. A caddy stocked with gloves and gowns located near the door. b. At 10:40 AM, Resident #29 asleep in bed, with the catheter bag and tubing lying on the floor beside his bed. c. At 5/13/25 at 10:57 AM, Staff C, Certified Nursing Assistant (CNA) walked by Resident #29 room as she pushed a cart in the hallway. Resident's catheter and tubing position remained on the floor. d. At 5/13/25 at 11:05 AM, Staff A, CNA entered Resident #29's room to ask about his plan for lunch. Staff A picked up the catheter bag from the floor and placed it in a dignity cover. Staff A then placed the bag and tubing back on the floor. e. At 5/13/25 at 12:12 PM, Resident #29 was asleep in bed. The catheter bag, in a dignity cover, and tubing rested on the room floor. During an observation of catheter care on 5/13/25 at 1:26 PM Staff Q, CNA donned gloves. Without wearing an isolation gown, Staff Q entered Resident #29's room. Staff Q placed paper towels on the floor and placed a graduated cylinder on top. Staff Q then drained the catheter bag into the graduated cylinder. Without cleaning the spigot with an alcohol wipe, Staff Q clamped it and placed in the holder area on the catheter bag. Staff Q attached the catheter bag and tubing off the floor, attached to the bed frame. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/25 at 2:06 PM, Staff H, CNA stated urinary catheter bags and tubing should never be on the floor, and Enhanced Barrier Precautions are used with all catheter care. Staff H stated after emptying a catheter bag an alcohol wipe should be used on the spigot. During an interview on 5/21/25 at 1:02 PM, the DON stated she would expect the staff to check the placement of catheter bags and tubing every shift and as needed as they should never be on the floor. The DON stated PPE (personal protective equipment) should be worn when emptying a catheter bag. The DON stated this would include the use of gloves and a gown. Review of the facility policy titled Enhanced Barrier Precautions, effective April 2025 included the following definition related to Enhanced Barrier Precautions: Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer for MDROs (multidrug-resistant organisms) to staff hands and clothing .Nursing home resident with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRO's. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well for residents with MDRO infection or colonization. The Identification and Application Guideline sections #3. Indwelling Medical Devices are defined as (but not limited to): b. Indwelling urinary catheters. Review of the facility policy titled Indwelling Urinary Catheters, effective May 2025, revealed an Infection Control section which directed, in part: 2. Maintain clean technique when handling or manipulating the catheter, tubing and drainage bag. b. Be sure the catheter tubing and drainage bag are kept off the floor

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, and resident and staff interviews, the facility failed to place the call lights within the reach for 2 of 3 residents reviewed (Residents #8 and #29). The facility reported a census of 32 residents. Findings include: 1. Review of the Minimum Data Set (MDS) dated [DATE] identified Resident #8 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 13 out of 15. The MDS list of diagnoses included arthritis, multiple sclerosis and malnutrition. The MDS indicated Resident #8 dependent on staff for toileting and bathe/showers; substantial/maximal assistance with eating, oral hygiene, dressing, personal hygiene and repositioning. Review of the Care Plan, Revision on 1/9/25, revealed a Focus area to address I have elected to have transfer bar on my bed. I have a diagnosis of MS (multiple sclerosis) and need transfer bar to help with bed mobility. [Name redacted] has been educated on the risk and benefits of side rails. Interventions included, in part: Make sure resident call light in within reach while in bed. During an observation on 5/13/25 at 9:40 AM, Staff B, Registered Nurse (RN), after providing wound care, left the room with the call light still on top of nightstand by Resident # 8 foot, out of his reach. During an observation on 5/14/25 at 9:00 AM, 9:45 AM, and 10:39 AM Resident #8 asleep in his bed with the call light located near his feet, out of his reach. On 5/14/25 at 12:29 PM, Staff N, Certified Nursing Assistant (CNA), observed leaving Resident #8's room, the call light located on the resident's nightstand near the foot of his bed. During an observation on 5/15/25 at 7:56 AM, Resident #8 asleep in his bed with the call light located on the nightstand near the foot of his bed. 2. Review of the MDS dated [DATE] identified Resident #29 as cognitively intact with a BIMS score of 15 out of 15. The MDS list of diagnoses included disorder autonomic nervous system, syncope and collapse (temporary loss of consciousness caused by a sudden drop in blood flow to the brain), and urinary retention. The MDS identified Resident #25 dependent on staff for toileting and lower body dressing; and required substantial/maximal assist with bathe/showering, putting on and removing footwear and personal hygiene. The MDS indicated Resident #29 utilized an indwelling urinary catheter. Review of the Care Plan, Revision on 8/8/24, revealed a Focus area to address [Name redacted] is a moderate risk for falls r/t (related to) hypotension (low blood pressure) and autonomic nervous system dysfunction (the autonomic nervous system regulates involuntary functions like heart rate, breathing, and digestion). Interventions included, in part: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 2/7/23. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/13/24 at 1:26 PM, Staff Q, CNA exited Resident #29's room with the call light located on the floor, out of the residents reach. At 2:45 PM, Resident 29 sat in his wheelchair sitting near the doorway to his room with the call light located on the floor near his bed. At 3:24 PM, Resident #29 in bed asleep with the call light located on the floor by his bed. During an observation on 5/14/25 at 9:03 AM, Resident #29 lying in his bed with the call light on the floor beside his bed. During an interview on 5/13/25 at 2:06 PM, Staff H, CNA stated before she leaves a resident room she would make sure the call light, table and water pitcher are in the residents reach. During an interview on 5/15/25 at 11:10 AM, Staff M, Licensed Practical Nurse stated staff should ensure that the call light is placed within the resident's reach. Most of them like it placed on the bedside table. During an interview on 5/21/25 at 1:02 PM, the Director Of Nursing stated she would expect nursing staff to check that all call light are within the residents' reach any time they are in the resident's room. Review of the facility policy titled, Answering the Call Light, approved October 2024 included Purpose statement which declared The purpose of this procedure is to respond to the resident's requests and needs. The General Guidelines section directed, in part: 5. When the resident is in bed or confirmed to a chair be sure the call light is within easy reach of the residents.