	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	XONSTRUCTION	(X3) DATE SURVEY COMPLETED
					с
		165344	B. WING		06/19/2023
IAME OF PP	KOVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 38 MAIN STREET	
SPIRE O	FGOWRIE	144 ¹		OWRE, LA 50543	
(X4) ID PREFEX TAG	(EACH DEFICIEN	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC EDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRU DEFICIENCY)	-
F 000	INITIAL COMMENT	s	F 000		1
\checkmark	Correction date:	4-20-2023			
B		e Nursing Home is not in CFR Part 483 Requirements			
		Facilities. The following			1
	deficiencies resulter	f from a complaint survey 13457-C, conducted June 13,			
		-C was substantiated.			
	Facility Census: 17				
F 689		zards/Supervision/Devices	F 689		
	CFR(s): 483.25(d)(1 000		
	§483.25(d) Accider	lts.			
	The facility must en				
		resident environment remains hazards as is possible; and			
		resident receives adequate			
	supervision and as accidents.	sistance devices to prevent			
	This REQUIREME	NT is not met as evidenced			
	by: Based on observa	tion, record review, facility		2	
		nterviews the facility failed to			
		alarm system or a plan in	1		
		opement. The door alarm			
		ork and the facility did not have			
		3, 2023. The facility reported			i.
		d 15 minute checks of the			
		mentation to verify, with no s noted. The investigation			
		ntrance alarms for the main			
		lining room failed to activate			
		and/or left the facility. The			
BORATOR	Y DIRECTOR'S OR PROVID	RUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE	(X6) DATE
· LA	charl Mar	shall		administrator	7-10-2
N U	the second s		matin Man anats he	a axoused from correcting providing it is determine	

FORM CMS-2567(02-09) Previous Versions Obsolute

Event ID: FEI711

Facility ID: IA0117

If continuation sheet Page 1 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2023 FORM APPROVED OMB NO 0938-0391

							0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN			(X3) DATE COMP	SURVEY PLETED
		165344	B. WING				C (19/2023
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		TU/LULU
ASPIRE O	F GOWRIE		1808 MAIN STREET				
				901	/RIE, IA 50543		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From page	e 1	F6	80			
	facility identified five						10
		ty's failure resulted in an					
	-	to the health, safety, and			1. C		
	security of the reside						
	The Iowa Departmen	t of Inspections Appeals					
	notified the facility of	the Immediate Jeopardy (IJ)					
		5:50 p.m. The facility					
		ine 13, 2023 through the					
	following actions:						
		the electrician on June 13,					
	2023 at 4:19 p.m. to			1			
		e door alarm. Within 20 an arrived and fixed the					
	alarm.	an annveu and inted the					
		ceived education that if the					
		Inction, they are to count the					
		immediately and a 15 minute					
		til the repair of the problem.	1				
	The staff are to imme						
		rector of Nursing, and give all		1			
	paperwork to the Ad	ministration daily.					
	The facility lowered t	he scope and severity from a					
		me of the survey after the					
	survey team verified						
	implementation of th	e Plan of Correction,					
	Findings include:						
	1 0- 6/10/00 -10 11	The second states of the secon					
		5 p.m. witnessed the front staff entered the facility.					
		stan entered the latility.					
	On 6/13/23 at 4:00 p	.m. with the facility					
		ed the door alarms on the					
		lity and the dining room door					
		ne facility. Both door alarms					
	failed to sound. The	Administrator went to the					
	alarm panel behind t	he south nurses' station. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

" A Facility ID: IA0117

If continuation sheet Page 2 of 11

			(X2) MULTIPLE CON		(X3) DATE S	0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPL	
					C	0.0000
	10 million (1997)	165344	B. WING	ET ADDRESS, CITY, STATE, ZIP CODE	06/1	9/2023
AME OF PF	ROVIDER OR SUPPLIER			MAIN STREET		
SPIRE O	F GOWRIE			/RIE, IA 50543		
				CTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	COMPLETION
E 690	O antinua d'Eromono		F 689			
F 689	Continued From pa	ncluded a sign that read "do not	1 000			
	front of the panel in	oserved the top of the door				
	alarm nanel with th	e door alarm's electrical cord				
	draped over the to					
	On 6/13/23 at 4:00	p.m., the facility's				
	Administrator repo	rted that she only knew that the				
	door alarm panel r	eeded a sensor or fuses				
		the alarm panel did not work				
	since 5/14/23.				-	
	On 6/13/23 at 4:15	5 p.m., Staff A, Regional Vice				
	President, denied	knowing that the front door and				
		alarms failed to sound when				
	opened. Staff A qu	estioned the facility's Director				
	of Nursing (DON)	about the door alarm system				
	not working. The l	DON explained that the facility's				
		not work since 4/13/23. She				
		ility started 15 minute checks later the previous facility				
	Administrator disc	continued the 15 minute checks.				
		ot recall the reason to				
		5 minute checks. Staff A				
		rified that the facility had no				
	documentation of	any 15 minutes checks in				
		Staff A reported that the facility				
		cumentation log that someone alarms as needed. Staff A				
		e facility needed to get the door				
		as soon as possible and that				
		n comes to the facility a staff				
		t the dining room door and front				
	door to make sur	e that no residents left the facility				
		vledge. Staff A confirmed and				
		larm panel did not work since				
		the facility failed to do any sure that no residents left the				
	facility.					
	Taumly,					1

PRINTED: 07/10/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 4 of 11

ATEMENT	S FOR MEDICARE &					<u>NO. 0938-03</u>
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	G		ATE SURVEY MPLETED
		165344	B. WING			С
	ROVIDER OR SUPPLIER		B. WING			06/19/2023
				STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
SPIRE O	FGOWRIE			1808 MAIN STREET		
				GOWRIE, IA 50543		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	IE APPROPRIATE	COMPLÉTI DATE
F 689	Continued From page	e 3	F 68	39		
	On 6/13/23 at 4:45 p.	m. the facility's Director of				
	Nursing (DON), expla	ained that the alarm system				
	went down on 4/13/2	3 and that she put 15-minute				
	checks in place and v	when she came back to work				
	on 4/15/23, the facility	y discontinued the 15-minute				
	checks. The DON col	nfirmed that the reason she				
	put 15 minute checks	in place was the fact that all				
	residents had a risk to	o leave the facility without				
	staff knowledge.					
	2. Resident #3's Minir	num Data Set (MDS)				
1		22/23 a Brief Interview for				
	Mental Status (BIMS)	score of 12, indicating				
	moderately impaired (cognition. The MDS listed				
	Resident #3 as indep	endent for transfers,				
	locomotion on and off					
	included discusses at	er or wheelchair. The MDS				
	dicorder major dense	f diabetes mellitus, anxiety				
	kidnov diegogo (poere	ssive disorder, chronic				
	kidney disease (poor abnormalities of gait (unicuoning klaneys),		the second se		
	(movement).	waik) and mobility				
	(movementy,					
	The Care Plan last rev	viewed 10/11/22 indicated				
	the following:					
	a. Resident #3 had the	e potential for impaired				
	cognitive function/imp	aired thought processes				
		of making decisions and a				
	BIMS score of 12.					
		risk for decline in activities				
	of daily living (ADL) fu					
	alagnoses of diabetes	mellitus and anxiety. The				
	Interventions instructe					
	transterred independe	ntly, walked with a walker				
	and an assistance of c	one person, may use a				
	wheelchair for longer of	distances, and can propel				
		r. Resident #3 had an order efused most of the time.				
	iu waik to méals, but n	eiused most of the time				

Facility ID: IA0117

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/10/2023 APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION		(X3) DATE COMP	SURVEY LETED
	a	165344	B. WING				C 06/19/2023	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COD	E		- 0m
ASPIRE O	FGOWRIE				MAIN STREET VRIE, IA 50543			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD B		(X5) COMPLETION DATE
F 689	The eMar - Medicatio 4/17/23 at 12:46 p.m. Resident #3 must am a day for edema (swe Resident #3 propelled the dining room and of therapy. The Health Status No p.m. identified that Re wheelchair that he co On 6/14/23 at 2:45 p. independently propel to the nurses' station On 6/15/23 at 11:00 a independently propel in a wheelchair. 3. Resident #8's MDS had short term memo impaired decision ma identified that Reside assistance of one per locomotion on the un unit. Resident #8 use The MDS included di infarction (stroke), co movements), restless pain, anxiety and ma Resident #8's Care P indicated the followin a. She has a risk for related to a diagnosis	n Administration Note dated , listed an order that bulate to meals three times elling) management. d himself in his wheelchair to did not want to walk after the dated 5/28/23 at 10:47 esident #3 used a uild self-propel for mobility. m. witnessed Resident #3 himself up the west hallway in his wheelchair. a.m. watched Resident #3 himself up the west hallway is himself up the west hallway s assessment dated 3/15/23 ory problems with moderately uking abilities. The MDS nt #8 needed limited rson with transfers, it, and locomotion off the id a wheelchair for mobility. agnoses of cerebral nvulsions (uncontrolled sness, agitation, chronic jor depression. Plan last reviewed 12/7/22 g: decline in ADL function s of a stroke (CVA) with	F	689				
	only one side of the b	weakness or paralysis of body) The Care Plan tion that she transferred with						

Facility ID: IA0117

If continuation sheet Page 5 of 11

		D HUMAN SERVICES				FORM	: 07/10/2023 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMPI	SURVEY
	2	165344	B. WING			06/	C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CI	ITY, STATE, ZIP CODE	1	
				1808 MAIN STREET			
ASPIRE O	F GOWRIE			GOWRIE, IA 50543	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG				(X5) COMPLETION DATE
F 689	assistance of one per a walker for short dist Uses a wheelchair for independently. The Health Status No p.m. listed that Resid mobility, that she cour right-sided weakness to make her needs kr to the smoke area an after smoking to wato recognize staff faces On 6/14/23 at 5:00 p. independently propel station to go into the hands on the wheels On 6/15/23 at 10:30 a propel herself indepe station to go into the 4. Resident #9's MDS identified a BIMS sco cognition. The MDS i needed extensive assi	son and can ambulate with tances with staff assist, r mobility and able move it te dated 5/28/23 at 10:18 ent #8 used a wheelchair for Id self-propel. She had with limited speech but able nown. Resident #8 went out d then returned to her room th her TV. She can and know names. m. witnessed Resident #8 ling herself by the nurses' dining room by using her	F 68	39			
	MDS included diagno blood pressure), cere disorders that affect r posture), and anxiety Resident #9's Care F risk for decline in ADI related to a diagnosis Care Plan included a	oses of hypertension (high obral palsy (a group of novement, muscle tone, and r. Plan indicated that she had a					
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: FEI71	11	Facility ID: IA0117	lf co	ntinuation she	et Page 6 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2023 FORM APPROVED

	CENTERS FOR MEDICARE & MEDICAID SERV					<u> </u>	B NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3)) DATE SURVEY COMPLETED
		165344	B. WING				C 06/19/2023
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		00/10/2020
ASPIRE O	FGOWRIE			1808	MAIN STREET		
		10. T		GOW	/RIE, IA 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	mobility. The Intervent assist Resident #9 with wheelchair. On 6/15/23 at 10:00 at independently propell by the nurses' station On 6/15/23 at 12:45 pt that she can propel he throughout the facility did not use foot pedal 5. Resident #6's MDS identified that he had problems with severel abilities. The MDS inco	theelchair for locomotion tion directed the staff to th propelling in her a.m. witnessed Resident #9 ing herself in a wheelchair with her feet. o.m. Resident #9 confirmed erself independently with her feet and that she	F	589			
	locomotion on the uni unit. Resident #6 used The MDS included dia depressive disorder a	t, and locomotion off the d a wheelchair for mobility. agnoses of dementia, major					
	identified the following a. Resident #6 had a function related to dia Care Plan Focus inclu she transfers with exter Ambulates short dista two persons. Uses a v locomotion/mobility wi in wheelchair-assist as b. Resident #6 had im	g: risk for decline in ADL gnosis of dementia. The ided the Intervention that ensive assist of two staff, nce with the assistance of wheelchair for primary th supervision. Propels self s needed, paired decision making gnosis of dementia and Focus included the					
	self-propelling in her v 7(02-99) Previous Versions Obso	vheelchair throughout			D: IA0117		

Event (D: FEI711

Facility ID: IA0117

If continuation sheet Page 7 of 11

ATEMEN'T C	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMP	SURVEY LETED
DELANOF	USKNEUTION		A, BUILDING			C
		165344	B. WING		0 <u>6/</u>	19/2023
AME OF PF	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CO	DE	
SPIRE O	F GOWRIE			MAIN STREET VRIE, IA 50543		
				PROVIDER'S PLAN OF C		(X5)
(X4) ID PREF1X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETIO DATE
F 689	Continued From page	e 7	F 689			
		mes. Staff document,				
		nd monitor location as				
	needed.					
	The Health Status Note dated 5/7/23 at 10:28					
		esident #6 propelled in the				
		he halls and dining room.				
	The Health Status N	ote dated 5/27/23 at 3:03				
		esident #6 continued to				
		d the building. Two staff				
		at midnight as she appeared				
	The Health Status N	ote dated 5/28/23 at 10:35				
		tesident #6 self-propelled in				
	her wheelchair arour	nd the facility. She stopped				
		nts' room and watched TV for				
	brief periods of time hall.	then she moved down the				
	The Health Status N	ote dated 6/12/23 at 2:12				
		Resident #6 experienced				
		pility, and constantly rolled				
	around the facility in	her wheelchair.				
	On 6/15/23 at 1:00 p	o.m. observed Resident #6				
	propel herself indep	endently with her feet in a				
		nt lobby area near the front				
	door of the facility.					
	On 6/15/23 at 12:45	p.m. Resident #9 confirmed				
	that Resident #6 cou	uld propel herself up and				
		vith her feet. Resident #9				2
		Resident #6 went up and at all hours of the day and				
	night.	at all nours of the day and				
	-					
	On 6/19/23 at 9:00 a	a.m. witnessed Resident #6		10 II.		neet Page 8

PRINTED: 07/10/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES OFNITEDO FOR L

PRINTED: 07/10/2023 FORM APPROVED

NME PLANOF CONFECTION DENTIFICATION INVESSE: A DULDING (C) OWE THEY NAME OF PROVIDER OR SUPPLIER INVESTIGATION INVESSE: A DULDING C ASPRE OF GOWNE STREET ADDRESS, ChT, STATE, ZP CODE 1980 NAM STREET C OWID D TOG EVENUERY CALL INVESTIGATION INVESSE: D C OWID D TOG EVENUERY CALL INVESSE: D C OWID D TOG EVENUERY CALL D PERCENTON RESCUENCES FILL D PREOK APPORT OR LSC DENTERVIE ON CONCENTION OR INCLOSE (EACH CONCENTRA APTION SHOLD BE CONCENTRA A		OF DEFICIENCIES					OMB NO	. 0938-039
Institute of PROVIDER OR SUPPLIER 165344 B. WIRG 06/19/2023 A3PRE OF GOWRE STREET ADDRESS, CITY, STATE, 2P CODE 1988 MAN STREET COVER, I, A 5043 MULTION PROVIDER ON SUPPLIER Ison And Street ADDRESS, CITY, STATE, 2P CODE 1988 MAN STREET COVER, I, A 5043 MULTION Ison ADDRESS, CITY, STATE, ADDRESS, CITY, STATE, 2P CODE 1988 MAN STREET COVER, I, A 5043 MULTION Ison ADDRESS, CITY, STATE, ADDRESS, CITY, STATE, 2P CODE 1000 MILLION 1000 MILLION PREPRINT Ison ADDRESS, CITY, STATE, ADDRESS, CITY, STATE, 2P CODE 1000 MILLION 1000 MILLION PREPRINT Ison ADDRESS, CITY, STATE, ADDRESS, CITY, STATE, 2P CODE 1000 MILLION 1000 MILLION PREPRINT Ison ADDRESS, CITY, STATE, ADDRESS, CITY, STATE, 2P CODE 1000 MILLION 1000 MILLION F 689 Continued From page 8 PREPRINT, ADDRESS, CITY, STATE, 2P CODE 1000 MILLION MultiPreprint Ison ADDRESS, CITY, STATE, 2P CODE 1000 MILLION 1000 MILLION MultiPreprint Ison ADDRESS, CITY, STATE, 2P CODE 1000 MILLION 1000 MILLION MultiPreprint Ison ADDRESS, CITY, STATE, 2P CODE 1000 MILLION 1000 MILLION MultiPreprint Ison ADDRESS, CITY, STATE, 2P CODE 1000 MILLION 1000 MILLION MultiPreprint Ison ADDRESS, CITY, ADDRESS, CIT			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			_		
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, Zip CODE ASPREE OF GOWRIE STREET ADDRESS, CITY, STATE, Zip CODE MAN DI SUMMARY STATEMENT OF DEFICIENCIES COWRIE, LA 50643 MAR DI RECHT DEFICIENCIES DEFICIENCY PREFX RECALT DEFICIENCIES IN TILL, RECALTORY OR LISC IDENTIFYING NFORMATION F 689 Continued From page 8 propel herself in the main dining room in her wheekchair with her feet 6. Resident #10's MDS assessment dated 4/9/23 identified a BMS score of 12, included included room and off the unit. Resident #10 did not use a mobility device. The MDS Included diagnoses diabetes melitus, chronic pain, schizophrenia, The Care Plan last reviewed 12/15/22 indicated that he had a risk for deeline in ADL function related to diagnosis of diabetes melitus and Schizophrenia. The Care Plan included an interventions that he could transfers and ambulates independently without use of adaptive devices. On 6/14/23 at 11:45 p.m, observed Resident #10 stand by the front entry door, met staff asked him to move away from the door, come, and sta down by the nurse's station. Resident #10 ambulated independently ambulate throughout the facility, with other resident in their weekchair in the front ubby by the television.			165344	B. WING				
ASPRE OF GOWRE 198 MAN STREET GOWRE, IA 59/3 ⁰⁴¹⁰ ⁰⁴²⁰ ⁰⁴²⁰ ⁰⁴²⁰ ⁰⁴¹⁰ ⁰⁴¹⁰ ⁰⁴¹⁰ ⁰⁴¹⁰ ⁰⁴¹⁰ ⁰⁴¹⁰ ⁰⁴¹⁰⁰⁰ ⁰⁴¹⁰⁰⁰ ⁰⁴¹⁰⁰⁰ ⁰⁴¹⁰⁰⁰ ⁰⁴¹⁰⁰⁰ ⁰⁴¹⁰⁰⁰ ⁰⁴¹⁰⁰⁰ ⁰⁴¹⁰⁰⁰ ⁰⁴¹⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰⁰	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	STATE ZID CODE	06/1	19/2023
GOWRIE, IA 59543 PREFX TA0 SUMMARY STATEMENT OF DEFICIENCES (EACH DERICENCY MUST BE PRECEDED & YELL, PECHADRAY OF LSC IDENTIFYING INFORMATION) PD TA0 PROUNDERSPLAN OF CORRECTION (EACH DERICENCY OF AND ALL PECHADRY OF LSC IDENTIFYING INFORMATION) DD TA0 F 689 Continued From page 8 propel herself in the main dising room in her wheelchair with her feet F 689 6. Resident #10'S MDS assessment dated 4/9/23 identified a BIMS score of 12, indicating moderately impaired decision making abilities. The MDS listed Resident #10 as independent with transfers, and required supervision with locomotion on and off the unit. Resident #10 did not use a mobility device. The MDS included diagnoses diabetes melitus, chronic pain, schizophrenia (a mental disorder that involves seeing and hearing things not there), and depressed mood. Resident #10 Care Plan last reviewed 12/15/22 indicated that he had a risk for decilie in ADL function related to diagnosis of diabetes melitus, schizophrenia. The Care Plan included an interventions that he could transfers and ambulates independently without use of adaptive devices. On 6/14/23 at 11:45 p.m. observed Resident #10 stand by the front entry door, whe staff asked him to move away from the door, come, and sit down by the nurses' staffor. Resident #10 stand by the front entry door, which staff asked him to move away from the door, come, and sit down by the nurses' staffor. Resident #10 stand by the front entry door, the staff asked him to move away from the door, come, and sit down by the nurses' staffor. Resident #10 stand by the front entry door, the staff asked him to move away from the door, come, and sit down by the nurses' staffor. Resident #10 ambulated independently ambulates throughout						, CIAL, ZIF GODE		
PHERK EACH Objector MUST BE PRECIDED BYILL PREVALATION OF LISC DEMEMPINION AFORMATION) PREFIX TAG REAL CONSCIENCE ATTOM SHOULD BE CROSS-REFERENCED TO THE APPORTUNE UPFCIENCY) Configure BALL F 689 Continued From page 8 propel herself in the main dining room in her wheelchair with her feet F 689 F 689 6. Resident #10's MDS assessment dated 49/23 identified a BIMS score of 12, indicating moderately impaired decision making abilities. The MDS listed Resident #10 as independent with transfers, and required supervision with locomotion on and of the unit. Resident #10 did not use a mobility device. The MDS included diagnoses diabetes mellitus, chronic pain, schizophrenia (a mental disorder that involves seeing and hearing things not there), and depressed mood. Resident #10 care Plan included an interventions that he could transfers and ambulates independently without use of adaptive devices. On 6/14/23 at 11:45 p.m. observed Resident #10 stand by the front entry door, whe set aff asked him to move away from the door, come, and sit down by the nurses' station. Resident #10 stand by the front entry door, come, and sit down by the nurses' station. Resident #10 stand by the front entry door, the staff asked him to move away from the door, come, and sit down by the nurses' station. Resident #10 stand by the front entry door, the staff asked him to move away from the door, come, and sit down by the nurses' statione issues, while willing with other resident in their wheelchair in the front lobby by the television. Description			1. The second		GOWRIE, IA 50543			
propel herself in the main dining room in her wheelchair with her feet 6. Resident #10's MDS assessment dated 4/9/23 identified a BiMS score of 12, indicating moderately impaired decision making abilities. The MDS listed Resident #10 as independent with transfers, and required supervision with locomotion on and off the unit. Resident #10 did not use a mobility device. The MDS included diagnoses diabetes mellitus, chronic pain, schizophrenia (a mental disorder that involves seeing and hearing things not there), and depressed mood. Resident #10 Care Plan last reviewed 12/15/22 indicated that he had a risk for decline in ADL function related to diagnosis of diabetes mellitus and Schizophrenia. The Care Plan included an Interventions that he could transfers and ambulates independently without use of adaptive devices. On 6/14/23 at 11:45 p.m. observed Resident #10 stand by the front entry door, the staff asked him to move away from the door, come, and sit down by the nurses' station. Resident #10 atand by the front entry door, the staff asked him to move away from the door, come, and sit down by the nurses' station. Resident #10 and lotter sident the facility. On 6/16/23 at 9:30 a.m. see Resident independently multiate throughout the facility with on waker, no balance issues, while visiting with other resident in their wheelchair in the front lobby by the television.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	K (EACH COR	RECTIVE ACTION SHOULI RENCED TO THE APPROF	DBE	COMPLETION
stand by the front entry door without a walker or wheelchair. On 6/14/23 at 4:30 p.m. witnessed Resident #10 stand by the front entry door, the staff asked him to move away from the door, come, and sit down by the nurses' station. Resident #10 ambulated independently throughout the facility. On 6/15/23 at 9:30 a.m. see Resident independently ambulate throughout the facility with no walker, no balance issues, while visiting with other resident in their wheelchair in the front lobby by the television.	F 689	propel herself in the m wheelchair with her fe 6. Resident #10's MD identified a BIMS scor moderately impaired of The MDS listed Resid with transfers, and rea locomotion on and off not use a mobility dev diagnoses diabetes m schizophrenia (a men seeing and hearing th depressed mood. Resident #10 Care PL indicated that he had function related to dia and Schizophrenia. Th Interventions that he of ambulates independe	nain dining room in her bet S assessment dated 4/9/23 re of 12, indicating decision making abilities. lent #10 as independent quired supervision with the unit. Resident #10 did rice. The MDS included hellitus, chronic pain, tal disorder that involves ings not there), and an last reviewed 12/15/22 a risk for decline in ADL gnosis of diabetes mellitus he Care Plan included an could transfers and	F	589			
RM CMS-2567(02-99) Pravious Versions Obsolete		stand by the front entr wheelchair. On 6/14/23 at 4:30 p.r stand by the front entr to move away from the by the nurses' station. independently through On 6/15/23 at 9:30 a.r independently ambula with no walker, no bala with other resident in t	y door without a walker or n. witnessed Resident #10 y door, the staff asked him e door, come, and sit down Resident #10 ambulated nout the facility. n. see Resident te throughout the facility ance issues, while visiting heir wheelchair in the front					
Event ID: FEI711 Facility ID: IA0117 If continuation sheet Page 9 of	RM CMS-2567	7(02-99) Previous Versions Obso	lete Event ID: FEI711		Facility ID: IA0117			

ATEMENT C		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CON A, BUILDING		(X3) DA	NO. 0938-039 ATE SURVEY OMPLETED	
					1	С	
		165344	B. WING			06/19/2023	
AME OF PR	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP C	ODE		
			1808	MAIN STREET			
ASPIRE O	FGOWRIE		GOW	/RIE, IA 50543			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
			E 000				
F 689			F 689				
		a.m. notice Resident #10					
		ig room by himself without					
	staff assistance.						
		steel and Alerman Test		•			
		ates, and Alarms: Test nd locks, policy dated					
		t steps for checking and					
	testing door alarms:	a steps for brickling and					
	a Check operation C	of magnetic door locks (if					
	applicable)						
	b. Inspect door lock	monitoring and operation and					
	inspect panic hardwa						
		ode and keypad operations					
	ii. Any magnetical	iy locked doors must					
	automatically unlock	during a fire alarm (verify					
	this during your norr	nal fire drill)					
	iii. Check any adv	anced features (optional					
	equipment)						
		transmitter to make sure the					
	door stays locked an						
		egress operation (if					
	applicable)	lesse hard for a fraction of a					
		lease hard for a fraction of a not open and alarm should					
		not open and alarm should					
	not sound	ire to the door release for the					
		ance period setting (normally					
	1-3 seconds)						
		ouid go into irreversible					
	unlocking sequence						
		arm will sound					
	C. Door wi	Il automatically open within (15					
	-30 seconds)						
		oor and reset the alarm					
	vi, Ensure signs	are placed on doors adjacent					
		e that read "Push until alarm					
		pen in 15 seconds."					
	VII. Contirm that I	he security panels at the					
	Nurse Station activi	ate when the door opened and		ity ID: IA0117		sheet Page 1	

PRINTED: 07/10/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES					OMB N	<u>0. 0938-0391</u>
AND PLAN O	FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
	ROVIDER OR SUPPLIER	165344	B. WING				C /19/2023
]	DF GOWRIE			18	REET ADDRESS, CITY, STATE, ZIP CODE 108 MAIN STREET OWRIE, IA 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE,	(X5) COMPLETION DATE
	that it properly indicate release. viii. Replace the bar annually, if applicable c. The facility permits doors in the following i. All staff must ha ii. Smoke detection iii. Facility must ha iv. Electrical locks power v. Locks must also triggered alarm or sprid. Test doors and hard and condition vii. Check door for so that no air gaps exis barrier doors viii. Check door cl ix. Confirm all door for inspection and are x. Confirm all door e. Document results of xii. Note any discr xiii. Contact manu The Operations of Door Report dated 6/13/23,	es the location of the door ttery to the door keypad keyed locks on interior situations: we keys on systems must be in place ave a full sprinkler system a must release on the loss of o release when at a nkler system. Ware for proper operation r proper seal when closed st between smoke or fire osure for obstruction or labels are clearly visible readily legible readily legible rs latch inspection in log book epancies in 'Remarks' facturer with any questions ors and Locks Logbook included documentation d the door alarms on the ng ng ng ng ng	F	689			

FC bsolete

Facility ID: IA0117

If continuation sheet Page 11 of 11

Aspire of Gowrie 1808 Main Street Gowrie, IA 505443 Phone: 515-357-5817

Provider's Plan of Correction Date Survey Completed: **June 19, 2023**

F 000: Initial Comments:

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies by Aspire of Gowrie. To remain in compliance with State and Federal regulations, the facility has taken or will take the following actions set forth in this plan of correction.

F689 Accidents/Hazards

The facility does and will continue to ensure that all door alarms are working properly throughout the facility and that all residents are in a safe and alarmed environment.

All residents have the potential to be affected by the deficient practice.

The DON/Designee educated staff on 6-19-23 regarding the proper procedure on notification and 15-minute checks if it is found that door alarms are not functioning properly. It is expected that all staff will know what to do and who to notify if door alarms are not functioning properly. This will be part of all new hire and agency staff orientation as well.

Administrator/Designee will perform daily door alarm checks and will audit as follows using the facility audit tool F689 Door Alarm Audit: 1x daily x 4 weeks; 1x weekly x 4 weeks; 2x monthly x 1 month; 1x monthly x 1 month. Compliance concerns will be addressed immediately upon notification. This will also be monitored monthly through the TELS system.

All findings will be submitted through the QA and QAPI process by the for further improvement implementation. Administrator/Designee will bring audit results to the monthly QAPI meeting.

Date of Compliance: June 20, 2023