STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165344	A. BUILDING _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF GOWRIE	1898 MAIN STREET GOWRIE, IA 50543

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

✓ JB

Correction date: 6-20-2023

The Aspire of Gowrie Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The following deficiencies resulted from a complaint survey regarding intake #113457-C, conducted June 13, 2023 - June 19, 2023.

Complaint #113457-C was substantiated.

Facility Census: 17

F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689	

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, facility records, and staff interviews the facility failed to have a working door alarm system or a plan in place to prevent elopement. The door alarm system failed to work and the facility did not have a plan since April 13, 2023. The facility reported that they completed 15 minute checks of the doors without documentation to verify, with no onsite observations noted. The investigation revealed that the entrance alarms for the main entrance and the dining room failed to activate when staff entered and/or left the facility. The

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachael Marshall	Administrator	7-10-2023

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

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F 689	Continued From page 1 facility identified five residents at risk for elopement. The facility's failure resulted in an Immediate Jeopardy to the health, safety, and security of the residents. The Iowa Department of Inspections Appeals notified the facility of the Immediate Jeopardy (IJ) on June 13, 2023 at 5:50 p.m. The facility removed the IJ on June 13, 2023 through the following actions: a. The facility notified the electrician on June 13, 2023 at 4:19 p.m. to come to the building immediately to fix the door alarm. Within 20 minutes the electrician arrived and fixed the alarm. b. The facility staff received education that if the door alarms do not function, they are to count the number of residents immediately and a 15 minute head count check until the repair of the problem. The staff are to immediately notify the Administrator and Director of Nursing, and give all paperwork to the Administration daily. The facility lowered the scope and severity from a "K" to an "E" at the time of the survey after the survey team verified the initiation and implementation of the Plan of Correction. Findings include: 1. On 6/13/23 at 3:45 p.m. witnessed the front door fail to alarm as staff entered the facility. On 6/13/23 at 4:00 p.m. with the facility administrator checked the door alarms on the front door of the facility and the dining room door on the east side of the facility. Both door alarms failed to sound. The Administrator went to the alarm panel behind the south nurses' station. The	F 689		

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F 689	Continued From page 2 front of the panel included a sign that read "do not plug in, thanks." Observed the top of the door alarm panel with the door alarm's electrical cord draped over the top of the panel. On 6/13/23 at 4:00 p.m., the facility's Administrator reported that she only knew that the door alarm panel needed a sensor or fuses replaced and that the alarm panel did not work since 5/14/23. On 6/13/23 at 4:15 p.m., Staff A, Regional Vice President, denied knowing that the front door and dining room door alarms failed to sound when opened. Staff A questioned the facility's Director of Nursing (DON) about the door alarm system not working. The DON explained that the facility's alarm system did not work since 4/13/23. She added that the facility started 15 minute checks and that two days later the previous facility Administrator discontinued the 15 minute checks. The DON could not recall the reason to discontinue the 15 minute checks. Staff A confirmed and verified that the facility had no documentation of any 15 minutes checks in place. In addition, Staff A reported that the facility did not have a documentation log that someone checked the door alarms as needed. Staff A confirmed that the facility needed to get the door alarm panel fixed as soon as possible and that until the electrician comes to the facility a staff member will be at the dining room door and front door to make sure that no residents left the facility without staff knowledge. Staff A confirmed and verified that the alarm panel did not work since 4/13/23 and that the facility failed to do any checks to make sure that no residents left the facility.	F 689		

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F 689	Continued From page 3 On 6/13/23 at 4:45 p.m. the facility's Director of Nursing (DON), explained that the alarm system went down on 4/13/23 and that she put 15-minute checks in place and when she came back to work on 4/15/23, the facility discontinued the 15-minute checks. The DON confirmed that the reason she put 15 minute checks in place was the fact that all residents had a risk to leave the facility without staff knowledge. 2. Resident #3's Minimum Data Set (MDS) assessment dated 3/22/23 a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS listed Resident #3 as independent for transfers, locomotion on and off the unit. Resident #3 normally used a walker or wheelchair. The MDS included diagnoses of diabetes mellitus, anxiety disorder, major depressive disorder, chronic kidney disease (poor functioning kidneys), abnormalities of gait (walk) and mobility (movement). The Care Plan last reviewed 10/11/22 indicated the following: a. Resident #3 had the potential for impaired cognitive function/impaired thought processes related to the difficulty of making decisions and a BIMS score of 12. b. Resident #3 had a risk for decline in activities of daily living (ADL) function related to the diagnoses of diabetes mellitus and anxiety. The Interventions instructed that Resident #3 transferred independently, walked with a walker and an assistance of one person, may use a wheelchair for longer distances, and can propel himself in a wheelchair. Resident #3 had an order to walk to meals, but refused most of the time.	F 689		

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F 689	Continued From page 4	F 689		

The eMar - Medication Administration Note dated 4/17/23 at 12:46 p.m., listed an order that Resident #3 must ambulate to meals three times a day for edema (swelling) management. Resident #3 propelled himself in his wheelchair to the dining room and did not want to walk after therapy.

The Health Status Note dated 5/28/23 at 10:47 p.m. identified that Resident #3 used a wheelchair that he could self-propel for mobility.

On 6/14/23 at 2:45 p.m. witnessed Resident #3 independently propel himself up the west hallway to the nurses' station in his wheelchair.

On 6/15/23 at 11:00 a.m. watched Resident #3 independently propel himself up the west hallway in a wheelchair.

3. Resident #8's MDS assessment dated 3/15/23 had short term memory problems with moderately impaired decision making abilities. The MDS identified that Resident #8 needed limited assistance of one person with transfers, locomotion on the unit, and locomotion off the unit. Resident #8 used a wheelchair for mobility. The MDS included diagnoses of cerebral infarction (stroke), convulsions (uncontrolled movements), restlessness, agitation, chronic pain, anxiety and major depression.

Resident #8's Care Plan last reviewed 12/7/22 indicated the following:
a. She has a risk for decline in ADL function related to a diagnosis of a stroke (CVA) with hemiplegia (extreme weakness or paralysis of only one side of the body) The Care Plan included the Intervention that she transferred with

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F 689	Continued From page 5	F 689		

assistance of one person and can ambulate with a walker for short distances with staff assist. Uses a wheelchair for mobility and able move it independently.

The Health Status Note dated 5/28/23 at 10:18 p.m. listed that Resident #8 used a wheelchair for mobility, that she could self-propel. She had right-sided weakness with limited speech but able to make her needs known. Resident #8 went out to the smoke area and then returned to her room after smoking to watch her TV. She can recognize staff faces and know names.

On 6/14/23 at 5:00 p.m. witnessed Resident #8 independently propelling herself by the nurses' station to go into the dining room by using her hands on the wheels of the wheelchair.

On 6/15/23 at 10:30 a.m. observed Resident #8 propel herself independently by the nurses' station to go into the dining room for an activity.

4. Resident #9's MDS assessment dated 3/4/23 identified a BIMS score of 15, indicating intact cognition. The MDS indicated that Resident #9 needed extensive assistance with transfers, locomotion on the unit, and locomotion off the unit. She used a wheelchair for mobility. The MDS included diagnoses of hypertension (high blood pressure), cerebral palsy (a group of disorders that affect movement, muscle tone, and posture), and anxiety.

Resident #9's Care Plan indicated that she had a risk for decline in ADL function related to a diagnosis of Cerebral Palsy. The Care Plan included an Intervention to transfer her with a sit to stand lift with the assistance of two.

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F 689	Continued From page 6 Resident #9 used a wheelchair for locomotion mobility. The Intervention directed the staff to assist Resident #9 with propelling in her wheelchair. On 6/15/23 at 10:00 a.m. witnessed Resident #9 independently propelling herself in a wheelchair by the nurses' station with her feet. On 6/15/23 at 12:45 p.m. Resident #9 confirmed that she can propel herself independently throughout the facility with her feet and that she did not use foot pedals. 5. Resident #6's MDS assessment dated 3/15/23 identified that he had short and long term memory problems with severely impaired decision making abilities. The MDS indicated that Resident #6 required extensive assistance with transfers, locomotion on the unit, and locomotion off the unit. Resident #6 used a wheelchair for mobility. The MDS included diagnoses of dementia, major depressive disorder and muscle weakness. Resident #6's Care Plan last reviewed 12/15/22 identified the following: a. Resident #6 had a risk for decline in ADL function related to diagnosis of dementia. The Care Plan Focus included the Intervention that she transfers with extensive assist of two staff. Ambulates short distance with the assistance of two persons. Uses a wheelchair for primary locomotion/mobility with supervision. Propels self in wheelchair-assist as needed. b. Resident #6 had impaired decision making ability related to a diagnosis of dementia and BIMS. The Care Plan Focus included the Interventions that Resident #6 enjoyed self-propelling in her wheelchair throughout	F 689		

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F 689	Continued From page 7 facility. Wanders at times. Staff document, re-direct, re-orient, and monitor location as needed. The Health Status Note dated 5/7/23 at 10:28 a.m. indicated that Resident #6 propelled in the wheelchair through the halls and dining room. The Health Status Note dated 5/27/23 at 3:03 a.m. reflected that Resident #6 continued to propel herself around the building. Two staff assisted her to bed at midnight as she appeared tired. The Health Status Note dated 5/28/23 at 10:35 p.m. identified that Resident #6 self-propelled in her wheelchair around the facility. She stopped outside other residents' room and watched TV for brief periods of time then she moved down the hall. The Health Status Note dated 6/12/23 at 2:12 p.m. identified that Resident #6 experienced anxiety, mood instability, and constantly rolled around the facility in her wheelchair. On 6/15/23 at 1:00 p.m. observed Resident #6 propel herself independently with her feet in a wheelchair in the front lobby area near the front door of the facility. On 6/15/23 at 12:45 p.m. Resident #9 confirmed that Resident #6 could propel herself up and down the hallways with her feet. Resident #9 acknowledged that Resident #6 went up and down the hallways at all hours of the day and night. On 6/19/23 at 9:00 a.m. witnessed Resident #6	F 689		

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F 689	Continued From page 8 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 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		

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F 689	Continued From page 9 On 6/19/23 at 11:15 a.m. notice Resident #10 ambulate to the dining room by himself without staff assistance. The Doors, Locks, Gates, and Alarms: Test operation of doors and locks, policy dated 6/13/23, documented steps for checking and testing door alarms: a. Check operation of magnetic door locks (if applicable) b. Inspect door lock monitoring and operation and inspect panic hardware i. Verify system code and keypad operations ii. Any magnetically locked doors must automatically unlock during a fire alarm (verify this during your normal fire drill) iii. Check any advanced features (optional equipment) iv. Check patient transmitter to make sure the door stays locked and alarm sounds v. Check delayed egress operation (if applicable) 1. Push door release hard for a fraction of a second-door should not open and alarm should not sound 2. Apply pressure to the door release for the pre-determined nuisance period setting (normally 1-3 seconds) A. Door should go into irreversible unlocking sequence B. Door alarm will sound C. Door will automatically open within (15 -30 seconds) D. Close door and reset the alarm vi. Ensure signs are placed on doors adjacent to the release device that read "Push until alarm sounds. Door can open in 15 seconds." vii. Confirm that the security panels at the Nurse Station activate when the door opened and	F 689		

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F 689	Continued From page 10 that it properly indicates the location of the door release. viii. Replace the battery to the door keypad annually, if applicable. c. The facility permits keyed locks on interior doors in the following situations: i. All staff must have keys ii. Smoke detection systems must be in place iii. Facility must have a full sprinkler system iv. Electrical locks must release on the loss of power v. Locks must also release when at a triggered alarm or sprinkler system. d. Test doors and hardware for proper operation and condition vii. Check door for proper seal when closed so that no air gaps exist between smoke or fire barrier doors viii. Check door closure for obstruction ix. Confirm all door labels are clearly visible for inspection and are readily legible x. Confirm all doors latch e. Document results of inspection in log book xii. Note any discrepancies in 'Remarks' xiii. Contact manufacturer with any questions The Operations of Doors and Locks Logbook Report dated 6/13/23, included documentation that the facility checked the door alarms on the following dates: a. 3/11/23, main building b. 3/18/23, main building c. 5/20/23, main building d. 5/27/23, main building e. 6/10/23, main building f. 6/17/23, main building	F 689		

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

Facility ID #165344

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