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

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 _____	10/14/2021

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 000	INITIAL COMMENTS Correction date: 11-09-21 The following deficiencies relate to the Recertification Survey, Complaints #98595, #99023, #99225, and Facility Reported Incident #100137 conducted October 4 - 14, 2021. Complaints #98959-C, #99023-C, and #99225-C were substantiated. Facility Reported Incident #100137-I was substantiated. The following deficiencies relate to the Federal Code of Regulations (42-CFR) Part 483, Subpart B.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-6-21

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and policy review, the facility failed to ensure residents were treated in a respectful and dignified manner for 4 of 8 residents reviewed (Residents #44, #53, #25, and #36) for dignity. The facility reported a census of 56 residents. Findings include: 1. The Minimum Data Set (MDS) dated 08/25/21 documented Resident #44 had diagnoses that included congestive heart failure, renal insufficiency, diabetes mellitus (DM), and a need for assistance with personal care. The MDS revealed Resident #44 had a brief interview for mental status (BIMS) score of 15, which indicated	F 550		

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intact memory and cognition. Resident #44 required two person physical assistance for transfers and extensive one person physical assistance for toilet use and personal hygiene. Resident #44 required a catheter for urination. The MDS coded the Resident always continent of stool.

Observation on 10/04/21 at 11:32 AM revealed Resident #44 in bed with a urinary catheter bag hanging from the bed and a fly swatter by his side.

In an interview on 10/04/21 at 11:32 AM, Resident #44 said he did not like the care at the facility. Resident #44 said the nurse this morning, Staff D, Licensed Practical Nurse (LPN), told him he had an attitude problem. The resident admitted he had an attitude that morning because it made him mad when Staff D told him he was rude. Resident #44 said he had a problem in the early hours of the morning when an aide came to empty his urinary catheter and spilled urine on his floor. Resident #44 said the aide did not clean it up and instead put a blanket over it. Staff D came in the morning and stepped on it. The Resident said Staff D was leaving his room and he asked if Staff D was going to clean up the urine and Staff D told him it would depend on his attitude. Resident #44 said he gave the staff respect when they gave him respect and he felt like the more he complained the worse things got.

In an interview on 10/04/21 at 11:49 AM, Resident #44 reported it sometimes took 45 minutes for staff to answer his call light. Resident #44 said he could only hold his bowels so long and he had a bowel movement twice in his bed because staff took too long to get to him. He reported he did

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not like going to the bathroom in his bed. In a follow up interview on 10/12/21 at 10:05 AM, Resident #44 reported when he had a bowel movement in his bed it made him feel mad and frustrated because grown men did not poop the bed and he was not normally incontinent of stool.

In an interview on 10/13/21 at 11:53 AM, Staff D, LPN recalled seeing urine on Resident #44's floor the morning of 10/04/21. She said Resident #44 told her the night aid was short with him and spilled urine on the floor. Staff D denied being rude to Resident #44, but stated she may have asked him why he had an attitude. Staff D said she left the room to gather supplies to clean the room and returned shortly after.

2. The Minimum Data Set (MDS) dated 07/22/21 documented Resident #25 had diagnoses that included anxiety, depression, heart failure and diabetes mellitus. The MDS revealed Resident #25 had a brief interview for mental status (BIMS) score of 15, which indicated intact memory and cognition. Resident #25 required extensive two person physical assistance for transfers, dressing, toilet use, and personal hygiene.

Observation on 10/04/21 at 04:19 PM revealed resident #25 covered with a top sheet soiled with light red spots at the bottom of the sheet that the resident reported were from juice he had spilled that morning at breakfast.

In an interview on 10/4/21 at 4:19 PM, Resident #25 reported incontinence of bowel and bladder that resulted from waiting too long for staff to respond to call lights. He reported he sometimes waited 45 minutes to an hour before staff answered his light. In a follow up interview on

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F 550	Continued From page 4 10/12/21 at 09:52 AM, Resident # 25, stated when he waited too long for staff to assist him and had a bowel movement in his bed as a result, it made him feel humiliated and like a grown man should not be incontinent of stool. A joint interview held on 10/05/21 at 9:27 PM, with Staff M, Certified Nursing Assistant (CNA), Staff L, CNA, Staff N, CNA, and staff O, LPN. Staff M acknowledged she had told residents they could do cares for themselves when they have asked for help. Staff M said the residents told her they were going to report her to the DIA (Department of Inspection and Appeals). Staff M admitted she told the residents they could call DIA. Staff M said she tries to support independence and if a resident is able to do their own ADL's (activities of daily living), she encouraged them to do so to prevent loss of function. Staff L, Staff M, and Staff N (all CNA's) acknowledged sometimes residents waited 30-40 minutes for call lights to be answered because a lot of residents were assist of 2 people and on evenings and nights they did not have enough people to answer the resident call lights in a timely manner. 3. The Minimum Data Set (MDS) assessment dated 9/18/21, revealed Resident #53 had diagnosis of chronic obstructive pulmonary disease (COPD), bilateral leg atherosclerosis of native arteries of extremities with intermittent claudication, right below the knee amputation, type II diabetes mellitus, and weakness. The MDS documented Resident #53 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition and no impairment with decision making abilities. The resident had total dependence of two staff for transfer and toilet use and was continent of bowel	F 550		

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F 550	Continued From page 5 and bladder The Care Plan revised on 10/4/21, revealed the resident had an ADL (activities of daily living) deficit related to amputation of right leg below the knee. The Care Plan indicated the resident needed staff assistance with toileting and required a mechanical lift with 2 staff for all transfers. On 10/04/21 at 12:20 p.m., Resident #53 was in bed on his back with the head of bed elevated and a hospital gown on. Call light was in reach. In an interview on 10/11/21 at 02:40 p.m. Resident #53 stated it sometimes takes up to an hour for staff to answer his call light and has resulted in him being involuntary in the bed while waiting for staff to assist him to the toilet using a mechanical lift. He stated he had been told by a certified nursing assistant (CNA) not to wait until the last minute to use his light to prevent involuntary episodes but he had the call light on for a long period of time prior. He stated it is demeaning. He felt it was bad enough to have to wait so long for staff to answer his light causing him to be involuntary but even more demeaning to have to lay in it until staff come to clean him up. He also reported when he asked for staff assistance at times he was told he can do take care of the request himself. 4. The Minimum Data Set (MDS) assessment dated 8/5/21, revealed Resident #36 had diagnosis of anxiety disorder, depression, bipolar disorder, psychotic disorder, post-traumatic stress disorder, asthma, coronary artery disease, heart failure and type II diabetes mellitus. The MDS documented Resident #36 had a BIMS	F 550		

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score of 13, which indicated intact cognition and no impairment with decision making abilities. The resident needed assistance of one staff for transfers, dressing and personal hygiene.

The Care Plan revise on 7/27/21, revealed the resident had an ADL deficit related to activity intolerance. The Care Plan indicated the resident needed staff encouragement to use the call light for assistance.

On 10/04/21 at 12:06 p.m., Resident #36 was lying in bed watching TV.

In an interview on 10/12/21 at 08:10 a.m. Resident #36 stated call lights take a long time to be answered. He reported he waited 45 minutes for staff to answer his call light last week. He stated he asked for the portable phone to be brought to him so he could call family. Staff told him they would bring it back and never returned. Resident #36 also stated the phones had been down since Friday, 10/8/21 and he hadn't been able to call his family nor had his family been able to contact him. He reported the facility had no options for him to contact his sick family member. He reported this was very upsetting to him.

In an interview on 10/12/21 at 03:29 p.m., the ADON stated it was her expectation staff ensure dignity and respect was provided to the residents at all times. She stated it was a priority and has been discussed at previous staff meetings. She stated it was her expectation if a staff person had an issue with a resident, they take it to the floor nurse so it can be addressed immediately and the situation be diffused and corrected at the time. She stated it was never appropriate to tell a resident to put their call light on sooner to prevent

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F 550	Continued From page 7 an accident or to tell a resident you will return and never come back. The facility provided an Abuse Policy dated August 2021. It revealed the facility was responsible for the actions of its employees, including intentional acts by employees who were aware they were doing something wrong and were in conflict with the facility's policies and procedures. It further stated the facility had the responsibility to provide interventions or services to meet the resident's needs from the time of admission. Staff members were expected to be in control of their own behavior and understand how to work with the nursing home population.	F 550		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating	F 567		

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F 567	Continued From page 8 accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents had same day access to personal funds and failed to consistently maintain petty cash funds for thirty-six resident accounts managed by the facility. The facility reported a census of 56 residents. Findings include: On 10/07/21 at 8:54 AM, the Activity Director was queried about disbursement of resident funds upon resident request. The Activities Director explained they worked Monday through Friday from 8:00 AM to 4:30 PM. The Activities Director explained if a resident approached them and asked if they could get money, a receipt would be filled out and acknowledged money would be handed to them as long as the resident had it in their account.	F 567		

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The Activities Director was queried who was responsible to dispense money on Saturday and Sunday, and acknowledged this did not occur. Per the Activity Director, residents would normally come and get enough money to cover the weekend. The Activity Director explained they only received so much money at a time, and further explained they had been out of money for awhile. Per the Activity Director, they had been giving everyone $25.00 a day until they were caught up. This way the Activity Director could start submitting receipts themselves and have money coming in more regularly instead of waiting for long periods of time. The Activity Director was queried how they obtained money to distribute to the residents, and explained when she first started doing the resident petty cash, the Business Office Manager (BOM) would give the Activity Director money, around $500.00 at maximum, and the Activity Director would give residents the money. When the total was down to $100.00, she would make the BOM aware so the BOM could complete her part of the process. The Activities Director explained the facility had just obtained money on Monday, October 4, 2021. Per the Activity Director,she had told the BOM around Labor Day that they did not have money. The Activities Director clarified since around the end of August the facility had not had any money to give to the residents.

The Activities Director explained she had given money to the residents from 8/13 to 8/23. The Activities Director provided a RESIDENT FUND MANAGEMENT SERVICE-WITHDRAWAL RECORD which documented withdrawals for the time period of 8/13 through 8/23 (year not documented on ledger). The next line on the

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ledger was dated 10/1, when the Activity Director explained she had realized they had $25.00 available. The next line on the ledger was dated 10/4.

The Activity Director was queried as to how the sum of $25.00 had been determined. The Activity Director explained she had been instructed to provide $25.00 a day until the facility got more money. The Activity acknowledged she did $25.00 to make sure that people who did not request money as often could get it.

On 10/07/21 at 10:42 AM, the Administrator was queried if there was a way for residents to access money on the weekends, and acknowledged he did not believe there was a mechanism to get cash off hours or on the weekends.

On 10/7/21 at 11:29 AM, the facility Administrator acknowledged those present on the Trial Balance sheet provided by the facility included everyone currently had used the trust fund. It was noted 40 accounts were documented on the list provided by the facility, however four of the forty accounts documented they had been closed.

On 10/11/21 at 11:28 AM, the Administrator explained per the regulation if a resident requested $100 or less or $50 or less than facility had to issue money to them on the same day. The Administrator further explained the plan was for the Activities Director to issue money the same day. The Administrator explained in the past month the facility had initiated a performance improvement plan for the matter.

The Administrator was queried about a time period when the facility had not had money to

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F 567	Continued From page 11 distribute, explained the Business Office Manager had not put in a request to replenish the funds, and acknowledged for approximately a month resident had not had access to money. On 10/12/21 at 9:00 AM the former Business Office Manager (BOM) was queried as to how often funds would be requested, and explained it would depend on how quickly residents went through the money. The BOM was queried if there was a time where there was no money to dispense, and explained there may have been times where they would have to wait a week or so until the money came in. On 10/11/21, a policy was requested for banking hours, the Administrator explained there was not such a policy, and the facility followed the regulation.	F 567		
F 570 SS=E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a surety bond which equaled at least the current amount of money present in the resident trust funds for thirty-six resident accounts managed by the facility. The facility reported a census of 56 residents. Findings include:	F 570		

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F 570	Continued From page 12 The facility's Surety Bond was requested from the facility Administrator. A Surety Bond was provided by the facility dated 10/6/21 for the amount of $5,000.00. The facility provided a Trial Balance sheet documented a list of residents at the facility who utilized the trust fund. It was noted 40 accounts were documented on the list provided by the facility, however four of the forty accounts had documentation present which stated the account had been closed. The Trial Balance documented account balances as of 10/07/21. The total current balance present on the Trial Balance sheet exceeded a sum of $5,000.00 (amount per the surety bond). On 10/11/21 at 11:28 AM, the Administrator explained the facility was waiting to have a new surety bond send for up to $80,000.00. Review of a document titled, Protection of Patient/Resident Funds and Beneficiary Designation, undated, documented, 8. The facility will purchase a surety bond or, as allowed by law, provide self-insurance to assure the security of all personal funds of Patients/Residents deposited with the Facility.	F 570		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and	F 576		

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ASPIRE OF MUSCATINE	2002 CEDAR STREET MUSCATINE, IA 52761

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F 576	Continued From page 13 facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, the facility failed to deliver unopened mail in a timely manner and failed to maintain a functional phone system for residents. The facility reported a census of 56 residents. Findings include:	F 576		

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1.In the Resident Council Meeting on 10/5/21 3 of 6 residents reported mail delivered with their name on it relating to revenue, social security, or appointments is opened prior to getting it. The residents stated they did not sign a release allowing the facility to open their mail. They also stated they did not receive mail on the weekends.

In an interview on 10/06/21 at 11:00 a.m., the Activities Director stated the mail comes to the facility daily and is delivered to the Business Manager. The Business Manager removed mail related to finances and placed the rest of the mail out front to be distributed. She stated she delivered personal mail such as cards, letters, and junk mail. The Activities Director verified she at times delivered opened mail to the residents. She stated she delivered mail daily Monday through Friday. On the weekends she asked the certified nursing assistants (CNA's) to deliver the mail. She told them if they were unsure if it should be delivered to the resident, they were to leave for the Business Manager to look through on Monday. She stated she was not sure how good the staff were about passing the mail on the weekends. She stated she had not had any complaints expressed about the mail not being delivered timely.

In an interview on 10/12/21 at 09:27 a.m., the Business Officer Manager stated she had been in the position since January of 2018. She stated when the mail came in, she went through it and placed any resident personal mail on top of her microwave for the Activities Director to deliver to the residents. She then went through the remainder of the mail and discarded junk mail and removed any bills, Social Security mail or other financial mail. She opened these items and

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distributed them to the Activity Director and the Social Worker for follow up. She stated she was unaware if the residents signed a waiver or release to allow staff to open their personal mail. She stated it may be in the admission packet. She was unsure if opened mail got rerouted back to the residents by the Social Worker or the Activities Director or filed away. She reported that the mail she opened normally does not get sent to the resident because it is distressing to them. She stated the mail was delivered daily Monday through Friday. Mail delivered to the facility on Saturday was locked up in the med room until the Business Manager retrieves it on Monday and was delivered to the residents at that time.

2. In an interview on 10/11/21 at 02:40 p.m., Resident #53 reported the facility phone had been down since Friday, 10/08/21 and staff and residents had been unable to place or receive calls all weekend.

In an interview on 10/12/21 at 08:10 a.m., Resident #36 reported he was unable to make or receive calls over the weekend related to the phone system being down since Friday, 10/8/21. He reported he was only notified the phone system was down when he asked staff to bring in the portable phone so he could call and check on his brother. He reported he did not have a cell phone and had no way to contact his family.

On 10/11/21 at 03:48 p.m., 10/12/21 at 08:15 a.m. and 10/13/21 at 10:27 a.m., telephone calls had been placed to the facility phone number, which did not go through.

In an interview on 10/11/21 at 04:00 p.m., the

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Administrator reported the facility phone number was 563-264-2023. He stated he was made aware Friday 10/8/21 that the phone system was not working. He stated it had been inoperable since Friday when an Information Technology (IT) employee came to update the internet service at the facility and it affected the telephone system. He verified they were unable to make outgoing calls or receive incoming calls from the phone system. He stated the phone company was aware and were unable to come over the weekend but the phone company was to have the issue resolved by Wednesday, 10/13/21. He stated families and residents had not been notified. He stated he planned to have the Social Worker send an email that afternoon.

In an interview on 10/11/21 at 04:12 p.m., the Assistant Director of Nursing (ADON) and the Social Worker reported they believed staff were using their cell phones to make calls out of the facility, notify the physician, or call 911. They stated they had not directed staff to carry a cell phone or ensured there was a cell phone available but believed that was the plan. When asked how residents were able to communicate or receive communication from outside the facility, they were unsure. They did state some residents had cell phones but there was no plan for those residents without one but acknowledged residents had complained.

In an interview on 10/12/21 at 08:34 a.m., the Social Worker reported she sent an email late yesterday afternoon to families/guardians and anyone she had emails for to let them know that the phone lines were down in the facility.

In an interview on 10/12/21 at 03:12 p.m., the

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F 576	Continued From page 17 Administrator reported the facility did not have a communication policy related to phone usage or mail.	F 576		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		

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F 584	Continued From page 18 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to provide clean shower rooms for 2 of 2 observed and failed to maintain clean common areas. The facility reported a census of 56 residents. Findings include: Observation on 10/04/21 at 11:59 AM, revealed mouse droppings at the end of the hallway near Room 56 and Room 57. Observation revealed a bug trap present near the hallway exit door. The trap contained multiple bugs. Observation on 10/05/21 at 10:04 AM, revealed Resident #23's privacy curtain contained multiple brown spots. Observation on 10/05/21 at 10:59 AM, revealed chipped paint on windows, dust and debris on floor below windows black substance on grout of tile in the shower in hall 2 shower next to Nurses Station 1. The toilet seat had a brown stain on it and the plastic had bubbling and peeling. During an observation on 10/11/21 at 10:10 AM, the shower room station 1 revealed two balls of black hair noted on the base board heater. Toilet soiled with dark substance on the seat and paper towels in the toilet bowl.	F 584		

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F 584	Continued From page 19 During an observation on 10/13/21 at 11:17 AM, the shower room at nurses station one on hall 2 unchanged from initial observation still has large amount of hair on heating register and black substance on the grout and tile. The paper towels remain in the toilet bowl. During an interview on 10/12/21 01:17 PM, Staff H (Housekeeper) stated the deep cleaning is done daily by housekeeping in the shower rooms they do the floor and the commodes daily. During an interview on 10/12/21 at 1:17 PM, Staff I (Housekeeper) stated deep cleaning is done daily by housekeeping in the shower rooms they do the floor and the commodes daily. During an interview on 10/13/21 at 12:14 PM, the Housekeeping Supervisor stated the shower cleaned daily. The black in the grout of the tiles in the shower room no longer comes off we have tried chemicals and wire brushes and nothing has been effective. She states she would expect privacy curtains to be changed when soiled. The staff should be cleaning up any mouse droppings when cleaning the floors daily. The facility provided a form with no date which indicates the shower room should be cleaned daily including the toilet , sweep/mop the floors and dust the heater/baseboards.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585		

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F 585	Continued From page 20 that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may	F 585		

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be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation

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F 585	Continued From page 22 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to ensure the residents had information on how to file a grievance for 6 of 6 residents at the Group Interview. The facility reported a census of 56 residents. Findings include: During the resident council meeting on 10/05/21 at 10:03 AM 6 out of 6 residents questioned the surveyor on how to file a complaint. They stated they do not know where the grievance procedure is located or who to contact with a grievance. During an interview on 10/05/21 at 12:00 PM the Administrator stated he was the Grievance Officer for the facility and he did not believe the grievance policy was posted anywhere in the facility or grievance forms were available to the residents. There was a grievance policy hanging on bulletin board outside the Administrators office from the previous owners dated 2017. He did provide a Grievance Policy from Aspire dated 3/2016. The Grievance Policy Dated 03/2016 provided by	F 585		

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F 585	Continued From page 23 the facility stated residents have a right to voice grievances and assure the facility is actively seeking a resolution. The facility is to provide written Concern/Complaint Procedure for Residents to the resident and/or family on admission. Grievances are to be documented on the Grievance/Complaint Report and be addressed as they arise and followed through until resolved. Initial grievance follow up by the designated individual is to occur within 72 hours.	F 585		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to offer showers as desired for 2 of 2 residents reviewed (Resident #7, Resident #41) for activities of daily living. The facility reported a census of 56 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated 8/25/21, Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15, this indicated intact cognition. Resident #41 required the extensive assistance of two plus persons physical assist for transfers, had impairment on both sides for lower extremities, and bathing was coded as activity did not occur. The Care Plan dated 3/16/21 documented, I have an ADL (activities of daily living) self-care	F 677		

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performance deficit r/t BL (bilateral) toe Amputation, Impaired balance, Limited Mobility, Loss of Vision. An intervention dated 6/10/21 documented, The resident requires assistance by staff with bathing/showering 2 times weekly and as necessary.

Shower sheets for Resident #41 were requested for September and October 2021. Two shower sheets were provided for the dates of 9/6/21 and 9/9/21.

Interview on 10/06/21 at 11:17 AM with Staff A, Licensed Practical Nurse (LPN) revealed showers were supposed to be completed two times a week, plus whenever else needed..

On 10/7/21 at 10:53 AM, the facility Administrator explained he presumed those were the shower sheets the facility had.

On 10/07/21 at 11:33 AM, Resident #41 was observed in bed in their room.

On 10/11/21 at 4:13 PM, the facility's Assistant Director of Nursing (ADON) was queried about frequency of resident showers, and acknowledged showers were to occur twice per week.

Review of a facility policy titled Resident Hygiene dated August 2021 revealed, Bathe each resident daily, to include a sponge and/or bed bath five times weekly (or more often, if needed) to including a tub bath, whirlpool bath or shower at least twice weekly. Tub and whirlpool baths or showers are scheduled for each resident and are given at various times of the day, modified according to the resident's condition, preferences

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and desires, whenever possible. Bathing includes cleaning and trimming fingernails and toenails, shaving facial hair, washing the entire body and shampooing resident's hair.
2. The MDS dated 07/06/21 documented Resident #7 had diagnoses that included neurogenic bladder, diabetes mellitus (DM), chronic lung disease, obesity and periodontal disease (gum disease). The MDS revealed Resident #7 had a BIMS score of 14, which indicated intact memory and cognition. Resident #44 required extensive assistance of 2 people for transfers. The resident required limited assistance of 1 person for dressing, toilet use, and personal hygiene. Resident #7 required a catheter for urination.

Observation on 10/04/21 at 1:50 PM revealed Resident #7 wore a hospital gown and purple sweatshirt. She had a disheveled appearance and hair appeared uncombed. Resident #7 reported she wrote on her calendar when she received showers and had 3 last month. She recorded a shower on 09/5, 09/8, and 09/25. The Resident said she wrote the days she had a shower on her calendar. Resident #7 reported staff only changed her clothes with showers and she wore the same clothes for over a week at a time. She stated staff did not wash her face, help brush her teeth or comb her hair in the mornings. She reported during baths, staff did not wash bottom of her feet or toes.

Observation on 10/05/21 at 09:54 AM revealed Resident #7 wore a hospital gown covered by a purple sweatshirt that appeared unchanged from observation on 10/4/21. Resident #7 stated she has not changed her clothes or been out of bed since her bath on 9/25/21. She reported her hair

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not combed and she has worn the same clothes since her bath on 9/25/21.

Observation on 10/06/21 at 03:08 PM revealed Resident #7 appeared to be wearing the same hospital gown covered with a purple sweatshirt. The Resident stated staff did not prompt or offer to help with ADL's this morning. The resident reported she had not yet washed her face, brushed her teeth or combed her hair. A brush noted within reach of the Resident. Resident #7 acknowledged she could reach the brush and was capable of brushing her own hair. The Resident did not ask staff for assistance. Resident #7 reported a shower scheduled later in the day.

Observation on 10/07/21 at 11:02 am revealed Resident #7 in a hospital gown covered with a long sleeve blue shirt. The Resident reported a bed bath last evening and changed clothes.

Observation on 10/11/21 at 12:55 PM revealed Resident #7 wore a hospital gown covered with a long sleeve blue shirt. The Resident stated she had not changed clothes, brushed her teeth, brushed her hair or had a bath since 10/07/21. Resident #7 said staff did not prompt or offer assistance yet on this day.

In an interview on 10/11/21 at 1:20 PM Staff G, CNA stated she was the CNA assigned to Resident #7's room. Staff G acknowledged she did not prompt resident to wash face, brush teeth, or change clothes yet on this day. Staff G said Resident #7 scheduled for a shower in the evening and had wipes within reach for her face the she could use.

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F 677	Continued From page 27 In an interview on 10/11/21 at 01:25 PM, the Assistant Director of Nursing (ADON) stated she expected residents bathed 2 times per week. She expected staff to try 3 times and residents were supposed to sign if they refused. CNA's then notified nurses for them to enter a note in PCC (Point Click Care electronic medical record). The ADON acknowledged Resident # 7's chart lacked this documentation. The facility records titled Bath/Skin sheets revealed Resident #7 received a shower 09/5/21, 09/8/21, and 09/24/21. The Resident received a bed bath 10/07/21. The Care Plan revised 10/04/21, revealed Resident #7 had a self-care deficit related to limited mobility. The Care Plan included the following interventions: a. Staff provide sponge bath/bed bath when the Resident refused regular bathing. b. Resident #7 totally dependent on 1 staff to provide shower 2 times per week and required assistance of 1 staff to dress. c. Oral care in the morning, after meals, and at bedtime. d. Resident #7 required assistance by 1 staff with personal hygiene and oral care e. Resident #7 sometimes resisted care and directed if Resident #7 resisted cares to reassure resident, leave and return 5-10 minutes later and try again. The facility policy titled Resident Hygiene dated	F 677		

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F 677	Continued From page 28 August 2021 documented a bath and shower standard of care included bathe each resident daily, to include a sponge and/or bed bath five times weekly including a tub bath, whirlpool bath or shower at least twice weekly. The resident encouraged to complete as much of their bathing and hygiene as they are able, per their plan of care. After the bath/shower is completed, the bath aide will assist the resident with dressing and grooming as needed or per care plan. The policy directed staff notify the supervising nurse of any resident who did not receive a bath/shower.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		

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receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on resident interviews, staff interviews and clinical record review, the facility failed to provide ordered urinary catheter care for 2 of 2 residents sampled (Residents #44 and #7) who required urinary catheters. The facility reported a census of 56 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 08/25/21 documented Resident #44 had diagnoses that included congestive heart failure, renal insufficiency, diabetes mellitus (DM), and a need for assistance with personal care. The MDS revealed Resident #44 had a brief interview for mental status (BIMS) score of 15, which indicated intact memory and cognition. Resident #44 required two person physical assistance for transfers and extensive one person physical assistance for toilet use and personal hygiene. Resident #44 required a catheter for urination.

In an interview on 10/04/21 at 12:04 PM, Resident #44 reported the provider ordered his urinary catheter flushed morning and night. The Resident voiced staff did not complete flushes as

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often as ordered and on 9/28/21 no flushes completed because the facility was short staffed.

In an interview on 10/07/21 at 1:25 PM Staff A, Licensed Practical Nurse (LPN), stated completed catheter flushes documented in the treatment record and the catheter flush completed for Resident #44 earlier in the day not yet documented. Staff A thought he documented the urinary catheter flush he completed for Resident #44 on 10/06/21 and acknowledged the possibility he forgot to document it. Staff A verified the facility had no record of urinary catheter flushes for month of October.

In an interview on 10/7/21 at 01:28 PM, the Corporate Nurse Consultant stated she expected catheter flushes documented when completed and acknowledged no record of catheter flushes for Resident #44.

The Medication Administration Record (MAR) for October 2021 lacked documentation catheter flushes completed for Resident #44 prior to 10/7/21. The MAR directed catheter flushes for Resident # 44 twice daily. The MAR periods for flushes included 6:00 AM-2:00 PM and 2:00 PM-10:00 PM. The facility did not provide a Treatment Administration Record that documented urinary catheter flushes completed for Resident #44 during the month of October.

The facility document titled Treatment Record for the month of September 2021 recorded urine catheter for Resident #44 flushed twice on 9/28/21.

The Order Summary Report for Resident #44, signed by the provider, contained active orders as

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F 690	Continued From page 31 of 10/01/21 that included catheter flushes with 60-120 milliliters of normal saline to prevent plugging and improper drainage two times a day. 2. The MDS dated 07/06/21 documented Resident #7 had diagnoses that included neurogenic bladder, DM, chronic lung disease, obesity and periodontal disease (gum disease). The MDS revealed Resident #7 had a BIMS score of 14, which indicated intact memory and cognition. Resident #44 required extensive assistance of 2 people for transfers. The resident required limited assistance of 1 person for dressing, toilet use, and personal hygiene. Resident #7 required a catheter for urination. In an interview on 10/05/21 at 09:53 AM, Resident #7 reported her catheter not flushed as ordered and sometimes her catheter not flushed at all. In an interview on 10/06/21 04:27 PM, Staff A, Licensed Practical Nurse (LPN), said he had not flushed resident #7's catheter yet. Staff A reported the Resident received catheter flushes daily. Staff A said Resident #7's catheter flush scheduled for 09:00 AM and was overdue. In an interview on 10/11/21 at 10:30 AM Staff A, stated catheter flushes documented in the treatment administration record. He acknowledged the treatment administration record (TAR) for Resident #7 lacked any documentation catheter flushes completed. In an interview on 10/11/21 at 10:39 AM the ADON, acknowledged catheter flushes for Resident #7 not documented. She did not know what happened. She reported the catheter	F 690		

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F 690	Continued From page 32 flushes were on last month's TAR records and somehow they did not get onto October's TAR. The TAR dated 10/07/21 lacked documentation catheter flushes completed for Resident #7 prior to 10/08/21. The TAR documented catheter flushes scheduled 6 AM-2PM daily. The Order Summary Report for Resident #7 signed by the provider contained active orders as of 10/1/21 that included a catheter flush with sterile water once daily.	F 690		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced	F 700		

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by:
Based on observation, clinical record review, and interview, the facility failed to obtain consent from the resident and or Resident Representative and complete an assessment for side rails/grab bars for 1 of 1 resident reviewed (Resident #16) who had grab bars. The facility reported a census of 56.

Findings include:

The MDS dated 07/15/21 documented Resident #16 had diagnoses that included renal insufficiency, diabetes mellitus, cerebral palsy, seizure disorder, anxiety, depression, and psychotic disorder. The MDS revealed Resident #16 had a Brief Interview for Mental Status Score of "10", which indicated moderate cognitive impairment. Resident #16 required extensive assistance of 2 people for transfers. The resident required limited assistance of 1 person for transfers, dressing, personal hygiene. The resident required extensive assistance of 1 person for toilet use.

Observation on 10/05/21 at 08:36 AM revealed 2 grab bars attached to Resident #16's bed. Resident #16 reported he used the grab bars to help with repositioning.

Review of Resident #16's clinical record lacked assessment and resident consent for grab bars/side rails.

In an interview on 10/11/21 at 11:23 AM, the Administrator acknowledged the facility did not have record of an assessment or consent for grab bars for Resident #16. The Administrator stated he did not know when grab bars started as

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F 700	Continued From page 34 an intervention for Resident #16. The Administrator questioned if assessment and consent needed because the resident had grab bars and not side rails. The facility policy titled Restraint Management Standard, dated August 2021, directed side rails and/or assist bars evaluated on admission and with change in cognition, mobility, or with significant change as noted on the MDS using the Side Rail Assist Bar Screen. If side rails and/or assist bars used to aid the resident in mobility and do not restrict freedom of movement, address the reason and use of the side rails in the progress notes and care plan. Resident/representative will complete side rail consent form.	F 700		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 725		

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F 725	Continued From page 35 (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to provide an adequate amount of nursing staff to provide safe and timely cares to residents. The facility reported a census of 56 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/18/21, revealed Resident #53 had diagnosis of chronic obstructive pulmonary disease (COPD), bilateral leg atherosclerosis of native arteries of extremities with intermittent claudication, right below the knee amputation, type II diabetes mellitus, and weakness. The MDS documented Resident #53 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition and no impairment with decision making abilities. The resident had total dependence of two staff for transfer and toilet use and was continent of bowel and bladder. The Care Plan revised on 10/4/21, revealed the resident had an ADL (activities of daily living) deficit related to amputation of right leg below the knee. The Care Plan indicated the resident needed staff assistance with toileting and	F 725		

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F 725	Continued From page 36 required a mechanical lift with 2 staff for all transfers. On 10/04/21 at 12:20 p.m., Resident #53 was in bed on his back with the head of bed elevated and a hospital gown on. Call light was in reach. In an interview on 10/04/21 at 12:20 p.m., Resident #53 reported the facility was short staffed and did not get him up timely to use the toilet resulting in him being involuntary in bed on more than one occasion. He stated call lights took from 5 minutes to over an hour to answer. He reported it could be up to 2 hours for staff to bring a lift in to toilet him. He stated he kept track how long it took for staff to answer his call light by watching the clock on his wall or the time on his cell phone. In an interview on 10/06/21 at 01:54 p.m., Resident #53 reported that staff on the evening and night shift at times have transferred him via mechanical lift with one person. He stated he knew they were not supposed to do that but they had no choice because they were short staff. In an interview on 10/11/21 at 02:40 p.m., Resident #53 reported 3 nights prior he put his call light on for assistance to the bathroom. Staff answered after 5 minutes and shut off the light and stated they would be back with assistance to help transfer him with the mechanical lift. He stated he waited another 30 minutes and put his light on again but had to wait an additional 40 minutes before staff came to assist him. Review of the facilities Lifting and Transferring Residents Guidelines for Clinical Staff revised on 8/20/21 did not address the number of staff	F 725		

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required for mechanical lift transfers.

Review of the LF2020 Easy Lift Sit-To-Stand's User Manual revealed they strongly recommend that two caregivers take part in the lifting process and that two attendants be used when transferring a patient to and from a wheelchair.

Review of the Hoyer HPL700 User Instruction Manual revealed staff are to have someone assist them when attempting to transfer a patient.

2. The MDS assessment dated 8/5/21, revealed Resident #36 had diagnosis of anxiety disorder, depression, bipolar disorder, psychotic disorder, post-traumatic stress disorder, asthma, coronary artery disease, heart failure and type II diabetes mellitus. The MDS documented Resident #36 had a BIMS score of 13, which indicated intact cognition and no impairment with decision making abilities. The resident needed assistance of one staff for transfers, dressing and personal hygiene.

The Care Plan revise on 7/27/21, revealed the resident had an ADL deficit related to activity intolerance. The Care Plan indicated the resident needed staff encouragement to use the call light for assistance.

On 10/04/21 at 12:06 p.m., Resident #36 was lying in bed watching TV.

In an interview on 10/05/21 at 08:34 a.m., Resident #36 reported he waited for his call light to be answered for 45 minutes to an hour or more. He stated he had fallen 3 times last month and had to yell out to get help. He reported he felt if staff checked on him regularly he would not

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have had to yell for help.

In a joint interview on 10/05/21 at 09:58 p.m. Staff L, certified nursing assistant (CNA) and Staff M, CNA reported it frequently took them up to 30-40 minutes to answer call lights in the back halls when there were only 2 CNA's at night as they had the heaviest cares. They shared there were 2 call light panels, 1 in the back and 1 in the front. They stated they did not know when call lights at one end was going off on the other end of the building. Both staff reported when working with 2 staff at night (1 in the front and 1 in the back) they have transferred residents with the mechanical lift by themselves. Staff reported they have tried radios but they were not effective and didn't work well. They reported staffing had been a problem since at least May 2021. They reported on Saturday, 10/2/21 there were 2 aides and 1 nurse for the entire building on the night shift.

In an interview on 10/11/21 at 03:13 p.m., Staff I, CNA, reported she had worked at the facility since the end of July and agency prior to that. She worked second shift. She reported they have run with 1 nurse, no med aide and 2 CNA's occasionally over the past weeks. When short staffed they were not able to give showers and were only able to walk around, make sure no one was on the floor and completed rounds. She reported when working short she had to help the staff person in the back with 2 person transfers. She reported she did call the Administrator and told him it was not safe to work with that low staff numbers as it put the residents at risk.

3. The Minimum Data Set (MDS) dated 07/22/21 documented Resident #25 had diagnoses that included anxiety, depression, heart failure, and

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diabetes mellitus. The MDS revealed Resident #25 had a brief interview for mental status (BIMS) score of 15, which indicated intact memory and cognition. Resident #25 required extensive two person physical assistance for transfers, dressing, toilet use, and personal hygiene.

Observation on 10/04/21 at 04:19 PM revealed Resident #25 lying in bed with a top sheet soiled with light red spots on the bottom of the sheet. Resident #25 reported he asked for a new top sheet in the morning because he spilled juice on it during breakfast. The Resident said the nursing assistant told him she did not have time to replace his top sheet and turned it so the spilled area was at his feet. The nursing assistant told him she would return with a clean sheet when she had time. In a follow up observation on 10/05/21 at 11:50 AM, the resident lied in bed with what appeared to be the same soiled top sheet. The top sheet had light red spots on the bottom of the sheet. The resident confirmed it was the same sheet and said he planned to ask staff again to change the sheet.

In an interview on 10/04/21 at 04:19 PM, Resident #25 reported the facility severely short staffed, especially the night shift. Resident #25 said sometimes there are only 2 nursing assistants and one nurse for the whole facility. He commented it sometimes took 45 minutes for staff to answer call lights. Resident # 25 reported incontinence of bowel and bladder because he waited too long for staff to answer his call light. Resident #25 said on 10/04/21 he hit his call light in the morning, he did not know how long it took, but felt it was too long and by the time staff answered his light he was incontinent of urine. He felt the second shift nurses had too

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much to do and did not have the time to take care of residents as he felt they should.

4. The Minimum Data Set (MDS) dated 08/25/21 documented Resident #44 had diagnoses that included congestive heart failure, renal insufficiency, Diabetes Mellitus (DM), and a need for assistance with personal care. The MDS revealed Resident #44 has a brief interview for mental status (BIMS) score of 15 out of 15, which indicated intact memory and cognition. Resident #44 required two person physical assistance for transfers and extensive one person physical assistance for toilet use and personal hygiene. Resident #44 required a catheter for urination. The MDS coded the Resident always continent of stool.

Observation on 10/4/21 at 11:56 AM revealed Resident #44 lying in bed with catheter hanging off bed and fly swatter beside him.

In an interview on 10/04/21 at 11:56 AM, Resident #44 reported the facility frequently short staffed, especially on evening and night shifts. He commented the facility staffed with 1 nurse and 1 aide for the whole building. Resident #44 reported his provider ordered urinary catheter flushes in the morning and at night. He said his catheter flushes not completed as frequently as ordered and sometimes not at all, because the facility was short staffed and the nurses did not have the time.

In an interview on 10/5/21 at 09:15 PM, with Staff O, Licensed Practical Nurse, LPN, she reported she usually worked 6 PM-6AM. On this day, she was the only nurse scheduled from 6 PM-6AM. Staff O said in the past, the facility scheduled 2

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nurses that worked nights, but over the past 2-3 weeks, typically only 1 nurse scheduled to work over nights. Staff O said she did not feel like she could give the quality of care she wanted to give and felt it unsafe. Lori mentioned the facility staffed better when DIA (Department of Inspection and Appeals) visited the facility.

In a joint interview on 10/05/21 at 9:27 PM with Staff L, CNA, Staff M, CNA, Staff N, CNA, and Staff O, LPN, all 4 staff felt they could not give quality care and said it was dangerous due to short staffing. Staff M, CNA said there were only 2 CNA's for the entire building on 10/02/21 between 6:00 PM and 10:00 PM. Staff M, CNA reported the facility should staff 5 CNA's for the evenings and 6 CNA's for day shifts. Staff M said on a good evening, the facility staffed 4 CNA's in the building for the evening shift. Staff L, CNA, Staff M, CNA, and Staff N, CNA said they could not answer call lights in 15 minutes. They reported because some residents required 2 people for assistance, it could be 30-40 minutes before a call light answered and residents had to wait.

In an interview on 10/6/21 at 4:33 PM, Staff A, LPN, stated he felt the facility is very understaffed. He felt he could not give the quality of care that he wanted to give and felt it dangerous for the patients. He reported he was the only licensed nurse working the floor for the entire building on this day and said it was difficult for him to get to his nursing treatments in a timely manner.
On 10/11/21 at 8:29 AM, Staff F, Certified Nursing Assistant (CNA), explained short staffing had being going on for way too long. Staff F acknowledged at times they had worked by

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themselves on second shift station two, which was a heavy and busy hall. Staff C acknowledged the facility did use a lot of agency staff, and even using agency the facility did not have a lot of staff. Per CNA F, residents would not get the time and attention they needed when they were short staffed.

On 10/11/21 at 8:50 AM, Staff E, CNA, acknowledged the facility was really short staffed and resident were not being taken care of per their request. CNA E explained some residents would use the bedpan and some residents would need to use the bathroom in their pants until they could get help because of short staffing. CNA E acknowledged a big worry was not being able to care for residents in an appropriate manner due to short staffing.

On 10/12/21 at 10:40 AM, Staff C, Scheduler, was queried about staffing numbers at the facility and explained the PPD (per patient day) for staffing was 6 CNAs on dayshift, 5 CNAs on 2nd shift, 4 CNAs on 3rd shift, 2 Medication Aides on day shift, and one Medication Aide on PM shift. Staff C further explained CNAs worked 8 hour shifts, Medication Aides worked 8 hour shifts, and nurses worked 12 hour shifts. Per Staff C, there would be nurses 6AM to 6PM, and there would be one nurse from 6PM to 6AM. Staff C acknowledged staffing concerns at the facility. Staff C explained every since COVID the facility had lost everyone. Staff C further explained in the past six months no one had been picking up. Per Staff C, 112 nurse shifts had been requested and 7 had been filled. Staff C also acknowledged some agency staff used by the facility had been receiving shift availability, while other agency staff did not receive shift availability.

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F 725	Continued From page 43 On 10/12/21 at 11:43 AM, the Administrator acknowledged there are times when staff felt they were staff challenged. The Administrator explained he conjectured at times the facilty was staff challenged. Staff C explained the facility did not have a specific staffing policy.	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a Registered Nurse (RN) served as a full-time Director of Nursing (DON), and failed to ensure a RN worked at least eight consecutive hours seven days per week. The facility reported a census of 56 residents. Findings include: 1. On 10/4/21 at approximately 10:40 AM, the	F 727		

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F 727	Continued From page 44 Administrator acknowledged the Director of Nursing would probably not return to the facility, and had last come into the facility on the 16th or 17th of September. It was noted the facility had an Assistant Director of Nursing (ADON), however the ADON was a Licensed Practical Nurse (LPN), not a RN. On 10/07/21 at 1:06 PM, the Regional Nurse Consultant was queried about the DON role, and acknowledged the facility was looking for a new DON. Review of job description titled Director of Nursing, undated, documented, The primary purpose of the Director of Nursing position is to plan, organize, develop and direct the overall operation of the Nursing Department to ensure that the highest degree of quality of care is maintained at all times...Education -Must possess, as a minimum, a Nursing Degree (RN) from an accredited college, university or nursing school. 2.) Review of the daily assignment sheets reveal no registered nurse coverage for the following days: September 10, September 15, September 16, September 20 , September 21, September 24 September 25, September 26 , September 29, September 30, October 4 and October 5. During an interview on 10/11/21 at 4:17 PM with the Assistant Director of Nursing she states there should be one eight hour shift of registered nurse coverage every day. During an interview on 10/11/21 at 4:18 PM states	F 727		

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F 727	Continued From page 45 therapy were supposed to have registered nurse coverage and the Director of Nursing was supposed to be their coverage but then she got COVID and never came back to work. She has been off work since September 16, 2021. We also have had two registered nurse quit and not able to find a registered nurse to replace them. 10/12/21 11:34 AM Administrator states if not on the daily sheets there is a presumption of no registered nurse coverage for those dates. He states the director of nursing last worked on 9/16/21.	F 727		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		

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F 761	Continued From page 46 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy review, facility staff failed to store drugs in accordance with currently accepted professional principles. Observation revealed 44 bottles of expired medications in 3 locations (Station 1 medication cart, Station 2 medication room, and the Floor Stock supply room). The facility reported a census of 56 residents. Findings include: 1. On 10/05/21 at 01:03 PM, observation of Station 1 medication cart with Staff B, Certified Medication Aide (CMA), revealed 7 expired stock bottles of medications: a. cranberry supplement, 450 mg tablets, 47 tablets expired 07/2021. b. multivitamin with minerals, dietary supplement tablets, 12 tablets expired 05/2021. c. cetirizine, 10 mg tablets, 87 tablets expired 07/2021 d. vitamin C, 250 mg tablets, 32 tablets expired 04/2021 e. second bottle of cetirizine 10 mg tablets, approximately 80 tablets expired 07/2021 f. Geri-kot sennosides, 8.6 mg tablets, 44 tablets, expired 03/2021 g. enteric coated aspirin, 325 mg tablets, 124 tablets expired 09/2021 Staff B acknowledged the expired medications, said she would dispose of them, and removed them from the medication cart.	F 761		

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F 761	Continued From page 47 2. On 10/05/21 at 03:13 PM, observation of Station 2 medication room with Staff D Licensed Practical Nurse (LPN), revealed 13 expired stock bottles of medications: a. acetaminophen, 500 mg tablets, 1 bottle b. acetaminophen, 325 mg tablets, 1 bottle c. miralax, 17 gm, 17.9 oz, 1 bottle d. enteric coated aspirin, 325 mg tablets, 2 bottles e. vitamin B 12, 100 mg tablets, 3 bottles f. Geri-kot sennosides, 8.6 mg tablets, 1 bottle g. cetirizine, 10 mg tablets, 1 bottle h. magnesium, 200 mg tablets, 1 bottle i. acetaminophen, 250 mg/aspirin 250 mg tablets, 1 bottle j. melatonin, 1 mg tablets, 1 bottle Staff D acknowledged the expired medications, said she would dispose of them, and removed them from the medication room. 3. On 10/5/21 at 03:29 PM, observation of the Supply Room that contained floor stock medications with the ADON and the Regional Nurse Consultant revealed 24 bottles of unopened and expired medications. a. vitamin B 12, 100 mg tablets, 14 bottles, b. enteric coated aspirin, 325 mg tablets, 5 bottles c. simethicone, 125 mg chewable tablets, 1 bottle d. Geri-kot sennosides, 8.6 mg tablets, 3 bottles e. Geri-lanta regular strength (antacid) 1 bottle In an interview on 10/5/21 at 03:45 PM, the Assistant Director of Nurses (ADON) and the Regional Nurse Consultant acknowledged the expired medications and said they would dispose	F 761		

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F 761	Continued From page 48 of them. The ADON said the facility completed monthly checks for expired medications and she expected expired medication exposed of in the drug buster. On 10/12/21 at 10:40 AM, documentation regarding inspections of drug storage by nurse or pharmacist requested from the ADON. She stated she did not know if the facility had documentation of inspections. The facility did not provide requested documentation. The facility policy titled Medication Administration Guidelines, dated August 2021, directed all expired medications removed from medication cart and destroyed per the Environmental Protection Agency guidelines/Pharmacy guidelines.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		

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serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and record review, the facility failed to store food and maintain a sanitary environment in the main kitchen. The facility identified a census of 56 residents.

Findings include:

On 10/4/21 at 10:30 AM during the initial tour of the kitchen observed the following:

a.) Rusted shelf below dish racks by the dishwasher
b.) Tile floor in kitchen is cracked in front of the stove
c.) three compartment sink leaking at the faucet
d.) window open between storage area and office area in the kitchen with large hole in the screen with large amount dirt/dust covered with torn tin foil
e.) mouse droppings in dry storage areas in the kitchen
f.) 8 ceramic tiles missing from in front of refrigerator bare floor exposed
g.) dry storage room mouse trap or other type of trap large plastic black box at entrance to storage room with mouse droppings back right corner of storage room and under large can rack in the storage room.

The following items were observed undated during the initial tour of the kitchen on 10/4/21 at 10:30 AM:

a.) large tin foil wrapped ham on the top shelf of

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F 812	Continued From page 50 the refrigerator half open not dated b.) 9 ham and cheese sandwiches c.) 5 peanut butter and jelly sandwiches d.) 2 egg salad sandwiches e.) sour cream open f.) powder sugar open in the cabinet and not dated. During an interview on 10/4/21 at 10:30 AM Staff J (Cook) stated all food should be dated when opened or at the time it is prepared. Observed on 10/05/21 at 11:16 AM, revealed no cover on the fluorescent light bulbs above the stove, have white substance with large amount of gnats sticking to them. Fuzzy debris on sprinklers in the hood over the stove. Review of the cleaning schedules provided by the administrator dated 9/27/21 through 10/3/2 reveal the evening shift is to sweep and mop the store room and was only checked off on 9/29/21. During an interview on 10/5/21 at 12:35 PM, Staff K (Cook) stated the tiles on the kitchen floor have been missing for at least 6 months. The windows are both broke and have been like that for about a year. Kitchen staff is responsible for cleaning the kitchen and the storage areas. We do have a cleaning schedule and it is posted in the kitchen. During an interview on 10/13/21 at 7:30 AM, the Maintenance Director stated they are supposed to be sending us some tiles to put down for the missing ones in the kitchen they have been out since the transition to the new company. The plan is to repair the floor in the kitchen, the new company is supposed to get the tiles but they have been missing for some time. The kitchen	F 812		

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F 812	Continued From page 51 staff is responsible for cleaning up the mouse droppings in the store room. The staff take out the screen sometimes in the kitchen. The screen in the kitchen is because staff take it in and out all the time and now they have broke the window. They should not be removing the window next to the air conditioner. During an interview on 10/13/21 at 3:30 PM, the Administrator provided cleaning schedules and states there is only one week of them available and they are not complete. He also states they do not have policies for labeling food items and cleaning the kitchen the only policy he could find for the kitchen was how to clean the can opener.	F 812		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions,	F 838		

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F 838	Continued From page 52 physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.	F 838		

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F 838	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a facility failed to complete a facility-wide assessment, affecting all 56 residents who resided at the facility. The facility reported a census of 56 residents. Findings include: On entrance to the facility on 10/4/21 an entrance conference was performed with the facility Administrator. At this time, a list of documents was requested from the facility, which included the facility assessment. On 10/06/21 at 1:40 PM, the Administrator explained some information for the facility assessment remained incomplete. The Administrator was queried about the previous facility assessment when he had entered the position, and explained the assessment was from 2019. On 10/6/21 at 4:26 PM, the facility provided a documented titled FACILITY ASSESSMENT TOOL dated 10/4/21 which remained incomplete. Date assessment reviewed with QAA/QAPI committee had been left blank. The facility assessment provided included examples of completion of sections which were to have been individualized to meet resident needs at the facility. The staff training/education and competencies section documented, 3.4. Licensed and certified nursing staff receive a variety of in-services throughout the year. The section titled Policies and procedures for provision of care and the section titled Working with medical practitioners only included an example of how to	F 838		

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 _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF MUSCATINE	2002 CEDAR STREET MUSCATINE, IA 52761

(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 838	Continued From page 54 complete the form, and had not been completed to specifically address the facility. Review of a Facility Assessment Tool document provided by the facility documented, Nursing facilities will conduct, document, and annually review a facility-wide assessment, which included both their resident population and the resources the facility needs to care for their residents.	F 838		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to conduct quarterly Quality Assessment and Assurance (QAA) Committee meetings, with the minimum required members in attendance. The facility reported a census of 56 residents.	F 868		

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 _____	10/14/2021

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 868	Continued From page 55 Findings include: Review of the facilities sign-in sheets revealed QA/QAPI meeting attendance sheets dated 01/26/2021 and 04/26/2021. The facility failed to provide attendance sheets for 10/2020 and 7/2021. During an interview on 10/05/21 at 3:15 p.m., the Administrator stated he had no record for the July 2021 meeting related to not being able to locate the sign in sheet. In an interview on 10/12/2021 at 09:47 a.m., the Administrator stated he did not have record of QAPI meetings in 2020. He stated he knew they were in non-compliance in this area. He stated he believed the committee is meeting quarterly at this time. Review of the facility's 2022 Quality Assurance/Performance Improvement (QAPI) Plan revealed the facility identified the following as members of the QAPI committee: Medical Director, Administrator/Chairperson, Director of Nursing, Social Worker, Activity Director, Environmental Director, Food Service Supervisor, Certified Nursing Assistant (CNA), Consultants (Pharmacy, Registered Dietician, Psychiatry), Therapy Manager, and Director of Housekeeping/Laundry. Review of the facility's 2022 QAPI Plan revealed the committee meetings are to be held monthly.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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 _____	10/14/2021

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 880	Continued From page 56 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 57 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview and facility policy review, the facility failed to ensure staff failed to perform dressing changes in accordance acceptable infection control techniques for 2 of 3 residents reviewed (Resident #18 and #41) observed for dressing changes. The facility reported a census of 56 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/21/21 documented Resident #18 had a	F 880		

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F 880	Continued From page 58	F 880		

BIMS of 15 and diagnoses which included chronic obstructive pulmonary disease, edema, gastroesophageal reflux disease, muscle weakness, chronic kidney disease stage 3, osteoarthritis, anemia, hypersensitivity lung disease, dementia, hypertension, depression, atherosclerotic heart disease, type 2 diabetes, and renal failure. The MDS documented the resident required assistance of one with transfers, ambulation, toilet use, personal hygiene and showering and set up/clean up assistance with mobility, personal/oral hygiene, and meals.

The Care Plan dated 7/21/21 recorded Resident #18 at increased risk for respiratory infections and pressure ulcer development and potential for impairment to skin integrity related to immobility and moisture.

During an observation on 10/11/21 at 11:30 a.m., Staff A (Licensed Practical Nurse) donned a pair of gloves upon entering resident #18's room. He used bandage scissors to cut kerlix and remove dressing to resident's right lower extremity. The scissors slipped from his hand and fell to the floor. He picked the scissors up and placed them on the resident's tray table. Staff A then removed his gloves and placed a new pair of gloves without performing hand hygiene. He used wound cleanser and gauze to clean the area, applied prescribed cream and rewrapped with kerlix. Gloves were removed and hand hygiene preformed. Staff A then picked up the bandage scissors and left the room without cleaning them after falling on the floor.

In an interview on 10/12/21 at 01:25 p.m., the Assistant Director of Nurses stated it was her expectation staff completing wound care perform

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F 880	Continued From page 59	F 880		

hand hygiene upon entering the room and before leaving the residents room and with any glove changes. If an item is dropped and is unneeded, staff were to leave it until the treatment is finished before picking it up. The item should be cleaned before leaving the room. If needed further for the treatment, it was to be picked up and sanitized, gloves removed, hand hygiene performed and new gloves donned.
2. The Minimum Data Set (MDS) for Resident #41 dated 8/25/21 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated the resident was cognitively intact. This assessment documented the resident had one stage four pressure ulcer present upon admission, entry or reentry, and diabetic foot ulcer(s).

The Face Sheet revealed diagnoses which included, in part, osteomyelitis and acquired absence of other right toes.

The Wound Consultation dated 10/6/21 documented, Wound #10 Right, Distal, Medial, Anterior Foot Toe 1st Cleanse/Protect Wound/Peri-Wound Cleanse wound with soap and water. Pat dry. Use to scrub the wound (mechanically debride). Secondary Dressing (Used to Cover Wound) Cover with Gauze Pad (103 sq cm or less) - Paint with antiseptic solution povidine/iodine 10% solution and allow to dry before covering with gauze. Bulky Roll Gauze 4.5" x 4.1 yds. Secure dressing with roll gauze.

Observation on 10/11/21 at 10:54 AM revealed Staff A (Licensed Practical Nurse) performed wound care to Resident #41's right foot. Resident #41 had a sock applied to the right foot which was removed. The resident's right foot was

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F 880	Continued From page 60 observed to be wrapped in gauze. Staff A A cut off the old dressing, doffed their gloves, and donned new gloves. Hand Hygiene was not observed to have been performed prior to donning new gloves. Wound care was then performed to the resident's right foot. The facility provided a document titled, HAND HYGIENE: WHY, HOW & WHEN, undated, documented the 5 moments for hand hygiene as before touching a patient, before clean/aseptic procedure, after body fluid exposure risk after touching a patient, and after touching patient surroundings.	F 880		

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

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F550 RESIDENT RIGHTS/EXERCISE OF RIGHTS

The facility does ensure residents are treated in a respectful and dignified manner.

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

Nursing staff were in-serviced on residents' right to dignity. Nursing staff were in-serviced on answering call lights as quickly as possible.

Administrator will monitor facility grievances and Resident Council minutes for concerns regarding dignity. A QAA audit tool for call light response time was developed.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 10/25/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

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F567 PROTECTION/MANAGEMENT OF PERSONAL FUNDS

The facility does ensure residents have same day access to personal funds and maintains petty cash funds for residents.

All residents with a resident trust account have the potential to be affected by the alleged deficient practice.

A weekend on-call rotation has been developed to ensure residents who request trust funds on weekends have access to it the same day, if the amount is $50.00 or less. The Activities Director and new Business Office Manager have been in-serviced on maintaining a petty cash supply.

A QAA audit tool has been developed to monitor compliance for four (4) weeks.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/09/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

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F570 SURETY BOND-SECURITY OF PERSONAL FUNDS

The facility purchased a surety bond to assure the security of all personal funds of residents deposited with the facility.

All residents with a resident trust account have the potential to be affected by the alleged deficient practice.

Facility's surety bond was raised to $80,000 on 10/11/21.

Administrator and/or designee will verify surety bond is sufficient to cover current resident trust balances monthly.

Date Certain: 10/15/2021

PLAN OF CORRECTION

Aspire of Muscatine
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F576 RIGHT TO FORMS OF COMMUNICATION W/ PRIVACY

The facility delivers unopened mail in a timely manner and maintains a functional phone system for residents.

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

Facility's new Business Office Manager was educated on resident mail remaining unopened. Facility nursing staff delivers any Saturday mail to residents on the same day. The technical issues with the phone system were resolved on 10/15/21 and the system has been functional since that time. Facility will implement an emergency cellular phone should the phone systems be inoperable for an extended period.

A QAA audit tool has been developed to verify resident mail is being delivered unopened. The Social Services Director or designee will audit one (1) time weekly for four (4) weeks.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/07/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

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F584 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility does provide clean shower rooms.

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

The bug trap containing multiple bugs was removed. R23's privacy curtain was replaced. The windows in the shower room were repainted. The dust and debris on the floor below windows were cleaned. The black substance on grout of tile in shower was removed. The toilet seat was replaced. The hair on the base board heater was removed.

The facility's environmental and maintenance staff were in-serviced on providing clean shower rooms and a home-like environment for residents.

A QAA audit tool has been developed to verify shower room cleanliness and a home-like environment. The Housekeeping Supervisor or designee will audit three (3) time weekly for four (4) weeks.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/09/2021

PLAN OF CORRECTION

Aspire of Muscatine
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F585 GRIEVANCES

The facility does ensure residents have information on how to file a grievance.

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

A conspicuous sign was posted in two locations instructing residents how they can file a grievance with the facility. The facility's grievance policy is made available upon admission and request.

The Resident Council staff liaison will review the resident grievance policy at meetings.

Date Certain: 11/09/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
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F677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

The facility does offer showers as desired for activities of daily living.

All residents who need assistance with ADLs have the potential to be affected by the alleged deficient practice.

R7 and R41 have since been offered and received multiple showers each since the time of the survey.

The facility's nursing staff was in-serviced on the facility's shower policy and ADLs relating to grooming and dressing.

A QAA audit tool has been developed to verify residents who need assistance with showering and ADLs are being offered a shower at least two (2) times a week, appear to be well groomed, and appear to be in clean and kempt clothes. The DON or designee will monitor for compliance by auditing three (3) times per week for four (4) weeks.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/09/2021

PLAN OF CORRECTION

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F690 BOWEL/BLADDER INCONTINENCE, CATHETER, UTI

The facility does provide ordered urinary catheter care to residents who require urinary catheters.

All residents who require urinary catheter care have the potential to be affected by the alleged deficient practice.

R7's urinary catheter was flushed on 10/6/21. R44's urinary catheter was flushed twice as ordered on 10/7/21.

Facility nurses were in-serviced on urinary catheter care, carrying out treatments as ordered, and subsequently documenting completed treatments timely.

A QAA audit tool has been developed to verify urinary catheter flushes are completed as ordered and subsequently documented. The DON or designee will monitor three (3) times weekly for four (4) weeks. An additional QAA audit tool has been developed to ensure catheter care orders are properly transcribed to the treatment administration record (TAR). The DON or designee will monitor for two (2) months.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/09/2021

PLAN OF CORRECTION

Aspire of Muscatine
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F700 BEDRAILS

The facility does obtain consent from residents or resident representatives and completes assessments for side rails/grab bars.

All residents who utilize or require bed rails have the potential to be affected by the alleged deficient practice.

The facility received informed consent from R11 for use of grab bars for repositioning. Facility completed a bed rail assessment.

Facility staff were in-serviced on facility's side rail policy.

A QAA audit tool has been developed to ensure residents who are using bed rails have consents and assessments. The DON or designee will audit once a week for four (4) weeks.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/09/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

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F725 SUFFICIENT NURSING STAFF

The facility does provide an adequate amount of nursing staff to provide safe and timely cares to residents.

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

Facility nursing staff were in-serviced on call light and minimal lift policies. The facility is actively hiring and recruiting for both licensed nurses and certified nursing assistants through a variety of mediums, including Indeed, Facebook, and local media. The facility advertises for full-time, part-time, and PRN shifts. The facility offers generous sign-on and referral bonuses for new employees. The facility has contracts with and utilizes seven staffing agency firms. The facility contracted with a new agency on 9/30/21. The facility hired a new Director of Nursing on 10/27/21.

A QAA audit tool for call light response time was developed.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/05/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

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F727 RN 8 HRS/7 DAYS/WK. FULL TIME DON

The facility does ensure a Registered Nurse (RN) serves as a full-time Director of Nursing (DON) and does ensure a RN works at least eight consecutive hours seven days per week.

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

A Registered Nurse was hired as the facility's new full-time DON on 10/27/21. The facility continues to advertise and recruit for licensed nurses, including RNs, through a variety of mediums, including Indeed, Facebook, and local media. The facility offers generous sign-on and referral bonuses for new employees.

The facility has hired both licensed nurses and certified nursing assistants since survey. The facility continues to advertise for licensed nurses and certified nursing assistants through a variety of mediums, including Indeed, Facebook, and local media. A Director of Nursing was hired on 10/27/21.

Facility will continue to assure adequate RN coverage.

Date Certain: 11/05/2021

PLAN OF CORRECTION

Aspire of Muscatine
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F761 LABEL/STORE DRUGS AND BIOLOGICALS

The facility does store drugs in accordance with currently accepted professional principles.

All residents who receive facility administered stock medications have the potential to be affected by the alleged deficient practice.

The ADON (LPN) immediately removed all expired stock medications from all medication carts and storage rooms. The expired medications were subsequently disposed in accordance with facility medication destruction procedures. Facility's licensed nurses and certified medication aides were in-serviced regarding proper medication storage and removing expired medications.

A QAA audit tool has been developed to ensure stock medications in the facility are not expired. The DON or designee will audit once monthly for three (3) months.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/08/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

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F812 FOOD PROCUREMENT, STORE/PREPARE/SERVE-SANITARY

The facility does store food and maintain a sanitary environment in the main kitchen.

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

Maintenance staff will treat rusted shelf. The tile floor in the kitchen will be treated. The three compartment sink leaking at the faucet was repaired. The window was treated and cleaned. Mouse excrement was cleaned and removed. Ceramic tiles were replaced. Mouse droppings were cleaned in all affected areas. All food and drink items have since been correctly labeled and dated. There is a cover on the fluorescent light bulbs above the stove. White substance and gnats cleaned. Fuzzy debris on sprinklers cleaned. Dietary staff were in-serviced on cleanliness and following cleaning schedules as well as properly labeling and dating all food and drink items.

A QAA audit tool has been developed to monitor for cleanliness and repairs. An additional QAA audit tool has been developed to audit for proper labeling and dating of food.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/09/2021

PLAN OF CORRECTION

Aspire of Muscatine
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F838 FACILITY ASSESSMENT

The facility has completed a facility-wide assessment.

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

A new facility assessment was developed and is complete.

The Administrator and QAA Committee will review the assessment at least quarterly and update as needed.

Date Certain: 11/09/2021

PLAN OF CORRECTION

Aspire of Muscatine
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Recertification Survey Date: 10/14/2021

This plan of correction is being submitted pursuant to the applicable Federal and State regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or State regulations or failed to follow any applicable standard of care.

F868 QAA COMMITTEE

The facility does conduct quarterly Quality Assessment and Assurance (QAA) Committee meetings.

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

A QAA meeting has been scheduled for 11/17/21 at 12:00 p.m. The Administrator, Medical Director, Director of Nursing, and several other facility management members will be in attendance.

At least four quarterly meetings for 2022 will be scheduled at the 11/17/21 QAA meeting, requiring the attendance of the Administrator, Medical Director, Director of Nursing, and several members of facility management.

The Administrator will monitor for compliance.

Date Certain: 11/05/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

This plan of correction is being submitted pursuant to the applicable Federal and State regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or State regulations or failed to follow any applicable standard of care.

F880 INFECTION PREVENTION & CONTROL

The facility does ensure staff perform dressing changes in accordance with acceptable infection control techniques.

All residents who receive dressing changes have the potential to be affected by the alleged deficient practice.

Facility nurses were in-serviced regarding proper hand hygiene, donning/doffing, and other infection prevention techniques. Nurses were also in-serviced on properly cleaning medical tools and equipment after possible contamination.

A QAA audit tool has been developed to ensure proper infection prevention techniques are utilized during dressing treatments. The DON or designee will perform return demonstration audits three (3) times weekly for four (4) weeks.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 11/09/2021

PLAN OF CORRECTION

Aspire of Muscatine
Facility ID #: 165585
Recertification Survey Date: 10/14/2021

This plan of correction is being submitted pursuant to the applicable Federal and State regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or State regulations or failed to follow any applicable standard of care.

STATE RULE 481-58.45(1)

The facility does ensure residents are treated in a respectful and dignified manner.

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

Nursing staff were in-serviced on residents' right to dignity. Nursing staff were in-serviced on answering call lights as quickly as possible.

Administrator will monitor facility grievances and Resident Council minutes for concerns regarding dignity. A QAA audit tool for call light response time was developed.

Results of the audits will be presented to the QA/PI Committee for review.

Date Certain: 10/25/2021