STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: __________________ The following deficiencies resulted from the facility's annual recertification survey and investigation of Complaints #121064-C, #121224-C, #121534-C, #121611-C, #121708-C, #122599-C, #122975-C, #123000-C and facility reported incidents #121126-I, #121679-I, #121695-I, #122976-I, #122984-I, #123023-I conducted August 19, 2024 to August 28, 2024. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	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 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 550	Continued From page 1	F 550		

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, staff interview, and record review the facility failed to ensure residents were treated in a dignified manner and ensure the right to consent to treatment honored for five of five residents reviewed for dignity/resident rights. (Resident #1, Resident #3, Resident #11, Resident #17, Resident #177). The facility reported a census of 31 residents.

Findings include:

1. Review of Resident #11's Minimum Data Set (MDS) assessment dated 6/1/24 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident had a diagnosis of schizoaffective disorder, bipolar type. Per this assessment, the resident received antipsychotics on a routine basis only.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 550	Continued From page 2	F 550		

The Care Plan dated 3/20/24 revealed, [Resident #11] is a smoker.

The Care Plan dated 3/5/24 revealed, [Resident #11] has little or no activity involvement r/t (related to) Depression, Poor adjustment to the facility/unit. The Intervention dated 4/3/24, revised 4/29/24, revealed the following: Scheduled activity times related to the urge to go outside and smoke. Pt (patient) must be in the common area from 0930-1030, 1230-1330 and 1530-1630 and staff is not to go find her to ask her if she wants to go outside to smoke.

The Behavior Note dated 6/25/24 at 1:02 PM revealed, Res (resident) was noncompliant at the beginning of shift. Went back to bed after am meal et (and) didn't have TED (thromboembolitic deterrent) hose on. She got angry saying there are no stipulations to her smoking et wrote a schedule for this nurse. Print out of Kardex was given to res (resident) stating the times she is to remain in the common area in order to smoke. Res interrupted this nurse every time I was on the unit. Res was not taken for 1st smoking break however res was in the common area et TED hose were on so res did go out to 2nd smoke break.

On 8/20/24 at 11:21 AM, Resident #11 interviewed in their room. The resident reported it seemed like every time she asked certain staff to take her out they said no. When the resident queried about smoking/TED hose, the resident said it bothered her.

On 8/21/24 at 11:09 AM during an interview with Staff B, Certified Nursing Assistant (CNA), Staff B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 550	Continued From page 3	F 550		

explained the resident's smoke breaks would be taken away for any little thing, and the resident would get in trouble for getting mad. Per Staff B, when queried if the resident had to meet certain requirements to smoke, Staff B responded if the resident did not have TED hose couldn't smoke, if went to bed after meals couldn't smoke, and needed to be up in the living room with TEDs on an hour before smoking time to be able to smoke.

On 8/21/24 at 3:01 PM during an interview with Staff I, CNA, Staff I queried as to who took Resident #11 to smoke. Staff I explained whoever the nurse allowed to out for the day. Staff I explained they normally declined. Staff I further explained it was at the discretion of the nurse she believed, and acknowledged the rules had been changed so many times.

On 8/22/24 at 11:41 AM, Staff C, CNA explained the following about Resident #11: Per Staff C, the resident had come up front (part of building) a month/month and a half ago. Per Staff C, she know they said the resident had to be up and about to be outside, and if in bed sleeping tell them not to wake up. Per Staff C, it was usually just her so not able to take out to smoke anyway, and explained it caused behaviors for the resident. Staff C further explained residents got upset but the same thing every day, and was only Staff C, so Staff C could not take them.

On 8/28/24 at 8:03 AM when queried about stipulations to go smoke such as TED hose, being up for certain amount of time, etc., the Director of Nursing (DON) explained smoking was not stipulated to anything like that, and was not acceptable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 550	Continued From page 4	F 550		

The Facility Policy titled Resident Rights and Dignity Management Dated October 2023 revealed, 1. Residents shall be treated with dignity and respect at all times. 2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

2. The Minimum Data Set (MDS) assessment for Resident#3 dated 5/3/24 reflected an admission date of 1/26/24. The MDS listed diagnosis that included, dementia, anxiety, and depression. The MDS revealed listed short- and long-term memory a problem with wandering behavior 1-3 days in the 7 day look back period.

The Care Plan for Resident#3 dated 3/20/24, reflected he lived in the secure unit due to vascular dementia. The Care Plan directed staff to observe for him for changes in moods and behaviors during care. The Care Plan identified psychiatric consults as indicated.

The Progress notes reflected Telemed Psych notes dated 3/18/24, 4/2/24, 4/16/24 and 5/7/24.

Resident#3's clinical record failed to include a consent for psychiatric telemed services.

On 8/26/24 at 5:20 PM, Staff N, Former Administrator reported she lacked knowledge of any issues related to consents for services. Staff N said she thought the nurses called and got the consents from the families for residents to get psychiatric care.

On 08/27/24 at 11:15 AM, the Chief Operation Officer (COO) reported the facility obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 550	Continued From page 5	F 550		

consents for some things, he sent the question to the Director of Nursing (DON).

On 8/27/24 at 1:29 PM, the Interim DON reported she failed to find any consent for Resident#3 to see psychiatric services. The DON reported the facility expected consents obtained for services for a resident to see providers that included psychiatric care.

The facility provided an undated Admission Packet. Included in the packet: Exhibit 4, Consent for treatment:
The Resident acknowledges that the Facility renders services to the Resident under the general and specific instructions of the Resident's Attending Physician. The Resident authorizes and directs Facility to provide routine and emergency care as the Resident's Attending Physician or designee may direct from time to time. If Resident's Attending Physician and such attending physician's on-call designee are unavailable and the Resident requires medical services, or if the Attending Physician has not seen Resident in accordance with the time frames established by law; then Resident authorizes Facility to obtain, on behalf of Resident, the services of any other physician licensed to practice medicine in this state, at Resident's sole expense (if not covered by Medicaid,Medicare or third-party payer) until Resident's Attending Physician is available, or Resident has selected a new
Attending Physician. In that event, Resident authorizes and directs Facility to provide routine and emergency care as required for Resident's well-being, health, and safety in accordance with the orders of such physician.

F 550 Continued From page 6 F 550

The facility provided a policy titled Resident's Rights and Dignity Management dated 10/23, identified the facility standard:
Our facility respects and promotes the right of each resident to exercise his/her autonomy regarding what the resident considers to be important facets of his/her life.

Review of the Self Determination and Participaton section revealed:
Point 1. Each resident shall be allowed to choose activities, schedules and health care that are consistent with his/her interests, assessments and plans of care, including:
a. Sleeping, bathing and exercise schedules
b. Personal care needs, such as bathing styles, grooming methods and dress, and
c. Health care scheduling such as times of day for therapies and treatments
Point 2. The staff shall inform the resident and family of the resident's right to self-determination and participation is preferred activities; gather information about the resident's personal preferences and document these preferences in the medical record; and include the preferences in the plan of care.
Point 3. The resident shall be encouraged to make choices about aspects of his/her life in the facility including: roommates, smoking.
Point 4. Residents shall be provided assistance as needed to engage in their preferred activities on a routine basis.
Point 5. Resident shall be encouraged to interact with members of the community both inside and outside the facility.

3. The Minimum Data Set (MDS), dated 6/01/24, revealed Resident #17 had severely impaired cognition. Diagnoses included non-Alzheimer's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 550		F 550		

Continued From page 7
dementia with verbal and wandering behaviors.

The Care Plan, revised 3/19/24, revealed Resident #17 had impaired cognitive function related to dementia. Interventions instructed staff to communicate using resident's preferred name and to speak on an adult level, speaking clearly and slower than normal.

On 8/19/24 at 11:09 AM, Staff Y, Certified Nursing Assistant (CNA) worked on the Chronic Confusion or Dementing Illness (CCDI) unit. Resident #17 approached Staff Y and showed her a stuffed animal she was carrying, Resident #17 said it was stupid, Staff Y responded to Resident #17, "just like you, you crazy".

4. The Minimum Data Set (MDS) assessment, dated 6/01/24, revealed Resident #1 had severely impaired cognition. Resident #1 required substantial to maximal staff assistance with transfers and cares. Diagnoses included non-Alzheimer's dementia, Schizophrenia, and anxiety disorder.

The Care Plan, revised 7/26/24, revealed Resident #1 had impaired cognitive function and impaired thought processes. Intervention instructed staff to communicate with Resident #1 using preferred name and provide resident with necessary cues.

On 8/19/24 at 11:43 AM, Staff Y, Certified Nursing Assistant (CNA) worked on the CCDI unit. Staff Y asked Resident #1 to propel self in wheelchair to the restroom. When Resident #1 bumped into wall along the hallway, Staff Y said to him, "Where are you going crazy boy?".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 550 Continued From page 8 F 550

5. Resident #177 admitted to the facility on 8/12/24. No Minimum Data Set (MDS) entry assessment or Medicare 5 day assessment completed or submitted, assessments remained in progress status.

The Baseline Care Plan, dated 8/12/24, revealed active diagnoses included dementia, severe, with agitation and violent behavior.

On 8/19/24 at 11:55 AM, Staff Y, Certified Nursing Assistant (CNA), worked on the CCDI unit. Resident #177 approached common area and attempted to sit on top of her four wheeled walker storage seat, Staff Y asked Resident #177, "what are you doing crazy?".

On 8/28/24 at 8:04 AM, the current interim Director of Nursing (DON), revealed that the term crazy would not be appropriate to when referring to residents and that staff are expected to call residents by their preferred name. DON informed that using the term crazy may come off as derogatory or rude and potentially cause residents to have behaviors, hurt feelings, or humiliation. DON stated she would educate staff if heard using this term.

F 600 SS=K Free from Abuse and Neglect
CFR(s): 483.12(a)(1) F 600

§483.12 Freedom from Abuse, Neglect, and Exploitation
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ___ B. WING ___	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 9	F 600		

corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on resident interview, observations, record review, and staff interviews, the facility failed to ensure residents were free from physical and emotional abuse. Resident # 77 was physically forced out of bed after the resident stated she could not stand or walk resulting in the staff needing to lower the resident to the floor. Resident #77 was lowered to the floor during the incident due to weakness and was forced to stand and transfer to the bed. Resident #77 voiced complaints of pain and fear of safety during transfers.

The facility also failed to provide supervision to prevent resident to resident abuse when Resident #22 identified as an alleged perpetrator involved in three verbal and physical altercations involving three residents. (Resident #17, #11, and #24).

The facility also failed to provide supervision to prevent potential resident to resident sexual abuse between Resident #20 and Resident #18.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 11, 2024 on August 22, 2024 at 3:15 p.m. As of the exit date, August 28, 2024, the immediacy was not removed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600	Continued From page 10	F 600		

The facility identified a census of 31 residents.

Findings Include:

1. At the time of survey, no Minimum Data Set (MDS) assessment had been completed yet.

The Progress Notes dated 8/7/24 at 1:29 p.m. recorded the resident admitted to the facility. The entry documented the resident required max assistance of 2 staff and unable to reposition herself.

The Progress Notes dated 8/7/24 at 2:34 p.m. recorded a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment.

The Progress Notes dated 8/7/24 at 5:55 p.m. recorded an Admission Summary that included the resident was unable to reposition herself or walk and needed lost of encouragement to perform even minimal tasks.

The Activity of Daily Living assessment dated 8/7/24 for Resident #77 revealed total dependence on 2 staff for bed mobility, transfers and toileting.

The Clinical Resident Profile documented Resident #77 as her own responsible party.

The Care Plan dated 8/7/24 failed to identify interventions for safe transfers for Resident #77.

The Progress Notes dated 8/8/24 at 5:55 p.m. documented two staff tried to perform an assistance of two person stand, pivot transfer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 11	F 600		

with gait belt. The entry recorded the resident argued with staff about getting up out of bed. The entry recorded that while transferring, the resident buckled her knees in an attempt to stop staff, the rresident lowered to the floor, and the resident sustained carpet burns to both knees. The entry documented after multiple attempts to get the resident up off the floor, the staff used the hoyer (full body mechanical lift) and assistance of 2 staff to lift the resident up.

The Progress Notes dated 8/9/24 at 4:09 a.m. documented the resident wanted to get up to use the restroom, but her knees buckled so staff used a hoyer lift. The entry also recorded the resident stated she was unable to move herself in the bed and that staff responded if the resident could not move in the bed independently or with assistance, then how could they walk to the bathroom and therefore the resident needed to use a bed pan. The entry documented the resident yelled out in pain so staff attempted to change her attend brief instead, but the resident refused.

The witness statement signed by Staff K, Certified Nursing Assistant (CNA) wrote on 8/11/24 at 2:44 p.m. that she was instructed by Staff D, Social Services/Activity Director (SS/AD) to assist Resident #77 to the toilet. A report on 8/10/24 instructed Staff K to utilize a mechanical lift for Resident #77 and Staff D stated only 1 person was needed and she could stand, pivot and assist the resident to the toilet. Resident #77 stated she could not stand. Staff D instructed Staff K to grab Resident #77 by the arm, stand her and pivot her to the wheelchair. Staff D wheeled resident to the bathroom, instructed her to stand using the grab bar, and when she could not, Staff D instructed Staff K to grab her arm, put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 12	F 600		

her on the toilet, then return resident to the wheelchair and bedside. Resident was lowered to the floor. Staff D instructed Staff K to help lift Resident #77 to the bed.

During an interview on 8/19/24 at 3:21 p.m., Resident #77 stated the staff dropped her after she was admitted and expressed fear of being dropped again.

During an interview on 8/22/24 at 9:47 a.m. Staff L, former Regional Nurse Consultant stated she had consulted with the Administrator and the Director of Nursing due to her concerns with staff who are not certified and providing patient care.

During an interview on 8/21/24 at 3:44 p.m., Staff M, Licensed Practical Nurse, (LPN) stated that management utilized their unlicensed / uncertified management staff as a second person when the cares required two certified staff.

During an interview on 8/22/24 at 10:24 a.m. Staff K, CNA stated that when she arrived for the 2p-10 p.m. shift she was confronted by Staff D. Staff K stated she thought Staff D was a CNA, as this was the first time meeting. Staff K stated Staff D was very aggressive with Resident #77, stating if she wanted to go home, she had to get up and walk. Resident #77 stated she could not stand and walk. Staff K stated Staff D told her to grab Resident #77's arm to sit her up and stand her. Staff K stated Resident #77 could not stand and it was like "dead weight" without a gait belt. Staff K stated she told Staff D that she could not force someone to do something but Staff D stated she was out of patience and spun Resident #77 into the wheelchair, pushed her to the bathroom and forced Resident #77 to the toilet by grabbing her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 13	F 600		

arm to stand her. Staff K stated Resident #77 continued to tell Staff D that she could not stand. Staff K stated after 2 minutes of Resident #77's inability to void, Staff D stated that she had to go home, instructed Staff K to grab her arm, pivoted and sat the resident in the wheelchair and wheeled her to the bedside. Staff K stated Staff D positioned with her back to the bed and took Resident #77 by the arm to stand her and the resident went to the floor with her feet straight out in front of her. Staff K stated her training taught her to get the nurse and a mechanical lift to help the resident back to bed after a fall. Staff K stated that Staff D said "No, grab her arm and lift her". Staff K stated they were able to stand Resident #77, then Staff D spun the resident who fell onto Staff D into the bed. Staff K stated the door opened and the DON stepped into the room, then stepped out and Staff J, CNA entered the room and assisted to get Resident #77 into the bed. Staff K stated she provided incontinent care and apologized to Resident #77. Staff K stated she went to the nurse's station, and reported the incident to the nurse since the DON and Staff D left the building. Staff K was instructed to report to the Administrator who was in the dementia unit. Staff K stated the Administrator instructed her to write a statement and place it on her desk.

During an interview on 8/22/24 at 11:21 a.m. Staff E, former Director of Nursing stated Resident #77 was refusing to get out of bed on the day of admission due to pain and weakness and was a maximum assist of 2 persons with a mechanical lift as she could not bear weight. Staff E stated on 8/11/24 she heard Resident #77 calling out, checked in on her and found Staff D, SS/AD and Staff K, CNA providing incontinent care for Resident #77. Staff E stated she has seen Staff D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600 Continued From page 14 F 600

providing care and giving showers to residents and was aware Staff D was not certified. Staff E stated she was not aware of Resident #77 being lowered to the floor or she would have made a report on that.

During an interview on 8/25/24 at 1:10 p.m. Staff J, CNA stated he was in fear of retaliation if he spoke with a surveyor and the corporation was setting the staff up for failure by not providing enough staff to provide care for multiple weeks. Staff J stated that Resident #77 was a 2 person assist and expressed her fear of being dropped. Staff J stated with the lack of staff, he has had to rely on the nurse to be the second person during care and when using the mechanical lift.

During an interview on 8/25/24 at 1:37 p.m. Staff Q, Licensed Practical Nurse (LPN) stated on 8/11/24 Staff K, CNA came up to the nurse's desk and said "I never want to do that again". Staff Q stated that Staff K explained that Staff D, SS/AD tried to make Resident #77 walk to the bathroom and she needed the mechanical lift up to the wheelchair. Staff Q stated Staff A, RN was present and took staff K to the Dementia unit to report the incident to the Administrator. Staff A then returned to the nurses station and wrote out a statement, then placed it on the Administrator's desk.

During an interview on 8/28/24 at 8:40 a.m. Staff D, SS/AD stated she had worked 8/11/24 on the 6a-2p shift. Staff D stated that she needed assistance for Resident #77 who needed the bathroom. Staff D stated that Staff K, CNA assisted Resident #77 up to the wheelchair and to the bathroom. Staff D stated she did have to assist the resident from the toilet to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET** **DONNELLSON, IA 52625**

(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 600	Continued From page 15	F 600		

wheelchair and to the bedside. Staff D stated that Resident #77 was falling and had to be lowered to the floor, down her leg and onto her feet. Staff D said Resident #77 urinated on her leg and "it was not a graceful transfer but it's better than being on the floor". Staff D stated she stood Resident #77 by "scooping her arm" and Staff K placed a gait belt on the resident and had her hands on the gait belt then transferred the resident to the bed. Staff D stated Staff E, DON peeked into the door then Staff J, CNA entered the room to assist. Staff D stated she left the facility then and did not visualize nursing staff to report the incident to. Staff D stated there are not enough staff to care for the residents and the Administrator was having noncertified staff providing care.

2. Review of the Admission Minimum Data Set (MDS) assessment dated 6/18/24 revealed Resident #22 scored 99 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was unable to complete the interview. Per this assessment, the resident had severely impaired skills for daily decision making, had inattention and disorganized thinking which fluctuated, and had verbal behaviors directed towards others.

Review of Medical Diagnoses for Resident #22 included other frontotemporal neurocognitive disorder.

Review of Resident #22's Baseline Care Plan dated 6/7/24, noted to be date of the resident's admission to the facility, revealed the following per the Social Services Section: Social services provided, mental health needs section, social services goals, and PASARR (Preadmission Screening and Resident Review) Level II

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600		F 600		

Continued From page 16
recommendations section questions were left blank, the behavioral concerns section revealed the following documentation: dementia, redirecting.

Review of a Medication Regimen Review (MRR) completed for Resident #22 dated 6/10/24 revealed the resident recently admitted to the facility, and noted the resident had three administration times on the medication administration record for Quetiapine, an antipsychotic medication, while the resident's hospital discharge records stated to give before dinner and bedtime. The MRR also noted the resident was on Quetiapine for purpose of insomnia. The Physician Response section documented, Agitation Bipolar.

Review of Resident #22's Care Plan created 6/17/24, last revised 8/4/24, revealed the following: The resident is/has potential to be physically aggressive. 6/20/24 resident had a violent outburst for the second time. Police and EMS (Emergency Medical Services) needed to intervene. See nursing notes for details. 7/18/24 violence towards another resident.

Review of a Staff Statement by [Staff F], CNA dated 6/20/24 revealed, on 6/20/24 at 10:00 PM, I, [Staff F], was attacked and assaulted by [Resident #22]. [Resident #22] was in another resident's room, [Resident #18] and [Resident #18] told him to get out. [Resident #22] then started to yell at [Resident #18] so I intervened and also asked [Resident #22] to leave [Resident #18's] room. He became angry, started yelling and using profanity towards me and tried to hit me but I stepped out of his reach. He then proceeded to follow me and chase me where we

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600		F 600		

Continued From page 17
ended up in the common area. He grabbed a wet floor sign and used it as a weapon hitting me twice about the head and several times on the forearm. I was able to get my phone and call the nurse [name redacted] and aide [name redacted] for help.

The Incident Note dated 6/20/24 at 10:36 PM revealed, nurse went to unit after heard yelling, and received cell call from CNA (Certified Nursing Assistant) on unit heard loud smacks, ran to unit, resident had CNA cornered in unit lobby smacking her over the head and arms with a wet floor sign, most words undiscernible, besides "F**K YOU", said residents name, turned then attempted to cont (continue) hitting CNA, stopped sign with hand then he was attempting to hit this nurse, "F**KYOU TOO" then was going to hit the CNA again, had him following me, opened unit door yelled for front CNA, resident moving furniture, told him you will not! He went and sat in recliner, when other CNA back, checked on unit CNA she stated she was ok, front CNA attempted to re-direct, stated "F**K YOU' unable to decipher more words. other residents coming out, unable to get [Resident #22] to go to different room, called Administrator and (Director of Nursing) DON, Sherriff called and EMS (Emergency Medical Services), when arrived resident semi calm, DON to call report to ER (Emergency Room) and contact POA. Fax sent to PCP (Primary Care Physician).

Review of a Fax Sheet dated 6/20/24 to the Physician for Resident #22 revealed, sent out ER (emergency room), [arrow sign up] behaviors, being sent back, assaulted resident earlier in the week or last week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600		F 600		

Continued From page 18

The Incident Note dated 6/20/24 at 11:00 PM revealed, called at home and notified of violent outburst pt (patient) was having (cornering and hitting staff with a wet floor sign). Police and EMS dispatched and pt transported to the hospital. Called report to ER and called [Company Redacted], POA, to advise or ER visit and that a plan of action needs to be implemented immediately for the safety of staff and visitors.

Review of the History and Physical Note dated 6/20/24 for Date of Service 6/21/24 revealed, in part, He has had some intermittent aggressive behaviors, mostly at night per the documentations.

Review of the Incident Note dated 6/21/24 at 1:30 AM revealed, in part, received call from [Name Redacted] in ER...nurse stated he was ready for discharge, explained that DON said we need a plan in place, to see what the plan is. That unfortunately they cannot keep him and with a TBI (traumatic brain injury) aggressive behaviors happen, and it's not their responsibility, its ours because we accepted him, and has been fine at ER. She said they could keep him till morning when plan in place. DON said to call POA about 1 on 1, to watch carefully. POA did not answer. Do not have staff in building for 1 on 1, to keep resident and others safe, since this has been reoccurring frequently with staff and other residents.

The Incident Note dated 6/21/24 at 10:34 AM revealed, several calls made to Dr [Name Redacted], Administrator, POA, [Name Redacted] Hospital and all of corporate involved, it is determined that pt will be coming back to facility as POA states they would require time and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600		F 600		

Continued From page 19
notification to try and find another placement and are not providing any additional assistance or resources. Staff will utilize 2 staff members to pick up pt (patient) from hospital as one does not feel comfortable traveling alone with him, pt will be on 1:1 status in the unit and additional help for coverage has been placed.

The Health Status Note dated 6/21/24 at 2:00 PM revealed, received call from [Name Redacted] hospital stating since they will not be admitting pt, he will be transported back to the facility per their arrangements. Pt arrived via secure car. Pt had paper scrubs on and his clothes were in a bag with the driver. Assisted pt out of the vehicle and into the facility due to unsteady gait. Had to pause at the nurse station due to the unsteady gait and then pt was walked back to the unit and placed in a recliner away from other residents. Pt will be monitored closely for any behavior changes.

Current interventions per the Care Plan included the following: (7/11/24): The resident's triggers for physical aggression are uninvited peers in his room. The resident's behaviors are de-escalated by peers going through his things and/or not leaving when asked to do so. additional staff have been in the unit to observe [Resident #22] closely. Potential incidents have been de-escalated. Staff have been having conversations with [Resident #22] in hopes of gaining his trust and exploring any activities he would like to participate in. (6/17/24): When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.

On 8/19/24 at 11:15 AM, Resident #22 observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING _______ B. WING _______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600	Continued From page 20	F 600		

standing in the hallway at a door, with head to the door. The resident was standing towards the door with a hand on the door handle.

RESIDENT TO RESIDENT ALTERCATIONS
a. Resident #22 and Resident #17:

Review of the MDS assessment for Resident #17 dated 6/1/24 revealed Resident #17 scored 99 on a BIMs exam, which indicated severely impaired cognition, and displayed verbal behaviors directed towards others and other behaviors not directed towards others.

Review of the facility's list of self reports revealed the incident type as allegation of abuse, incident date 6/12/24, which involved Resident #22 and Resident #17. Review of Resident #22 and Resident #17's progress notes in the electronic health record lacked documentation an incident occurred on 6/12/24.

Review of an Investigation Report dated 5/12/24, with narrative dated 6/12, revealed the following: Both [Resident #17] and [Resident #22] resident on the CCDI (chronic confusion dementing illness) unit. [Resident #17] is a former hotel housekeeper, she needs redirection often not to "check rooms" for tidiness, etc. On June 12th [Resident #17] made her way to [Resident #22's] room where she made her way to his closet and began moving his clothes around and would not leave the room or stop rummaging through [Resident #22's] clothes despite several requests from [Resident #22] to do so. [Resident #22] became frustrated with the situation and began to escort her to his door. [Resident #17] turned to face [Resident #22] and began to yell and [Resident #22] struck [Resident #17] in the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 21	F 600		

side of the face. [Resident #17] pushed [Resident #22] and he struck her again in the same side of the face. CNA [Name Redacted] heard yelling as she was walking down north hall to let residents know it was time for lunch. [Name Redacted] heard the yelling and started towards [Resident #22's] room and witnessed [Resident #22] hit [Resident #17], her push him and then [Resident #22] strike her again.

Review of the Conclusion section of the Investigation Report revealed, [Resident #17] would not leave peer [Resident #22's] room despite his request for her to do so. [Resident #22] was triggered by her refusal to leave his room and then beginning to yell at him. His dementia and PTSD (Post Traumatic Stress Disorder) dx (diagnosis) contributed to him reacting. [Resident #22] shared during interview that he had not intended to harm [Resident #17], he was remorseful for actions.

The Communication with Family/NOK/POA Note dated 7/2/24 at 5:10 PM present in Resident #22's electronic health record revealed, Notified POA of incident that occurred between [Resident #22] and another resident.

The Health Status Note dated 7/2/24 at 5:15 PM revealed, [Resident #22] placed on 1:1 observation due to behaviors and an incident between him and another pt (patient).

Review of Incident Reports provided for Resident #22 lacked an incident report for 7/2/24.

Review of the facility's Self Report list revealed an allegation of abuse had been reported between Resident #22 and Resident #17 for incident date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600	Continued From page 22	F 600		

7/2/24.

Review of the Incident Report dated 7/2/24 for Resident #17 revealed, CNA reports she heard resident arguing with another resident and the other resident was holding her cane. Resident states, "He hit me with his hand" and points to her right cheek. 1 cm (centimeter) linear area noted to right cheek. Resident denies pain or discomfort and states "I'm alright". The Immediate Action Taken section documented, in part, the two of them separated and the accused resident now 1:1 with staff/resident ratio.

Progress Notes for Resident #22 revealed the following:

The Communication with Provider Note dated 7/3/24 at 3:22 PM present for Resident #22 revealed, Objective: [Resident #22] is having unpredictable violent behaviors. Assessment: Pt has had multiple physical outbursts with other patients and staff, especially females. Plan: With each incident, [Resident #22] has had 1:1 observation from staff. Staff have made sure to keep close observation of him if he leaves his room and pt has been soft spoken and pleasant for several days after each incident. Dr [Name Redacted] and myself spoke directly with pt, he has no complaints and does not feel he requires any medications. States he "feels ok, don't need nothing". Haldol 2 mg TID (three times per day) will be ordered for his unpredictable behavior. We will continue 1:1 observation as long as there is staff availability. Tables will be moved and set up near hallway so all staff can observe his movement throughout the unit. POA will be notified, regional nurse was notified and administrator involved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 23	F 600		

The Communication with Family/NOK/POA Note dated 7/3/24 at 3:36 PM revealed, POA (Power of Attorney) notified of medication change due violent outbursts.

The Behavior Note dated 7/5/24 at 3:28 PM revealed, nurse was notified by staff that [Resident #22] attempted to hit staff with a broom and the incident was unprovoked. [Resident #22's] behavior was requiring facility to have extra staff present for violent outbursts. Staff was on alert with their observation of him and his behavior, so no contact made with the broom and the situation was deescalated immediately.

The Communication with Family/NOK/POA Note dated 7/18/24 at 11:39 PM revealed, after a long conversation with [Resident #22's] [family relationship redacted] yesterday, he told me that his [Resident #22] is prone to violence and has always been. He was kicked out of his apartment before the accident due to a physical altercation with his roommate. He has pushed most of his family away due to this behavior.

Observation on 8/19/24 at 11:17 AM revealed Resident #17 opened the door across the hall from the resident room where she resided, noted to be the room of a different resident (not that of Resident #22), and said he's asleep in there, and said she checked on him.

Observation on 8/25/24 at 10:16 AM Resident #17 opened the resident room door of the room they were in. Debris were observed on the floor outside of the resident's room. Resident #17 said they were trying to figure out how to clean that up, then said, "Have you seen my daughter?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600		F 600		

Continued From page 24

On 8/21/24 at 11:09 AM during an interview with Staff B, Certified Nursing Assistant (CNA), Staff B explained the following about Resident #17 and Resident #22: Staff B explained she'd seen Resident #22 punch Resident #17 in the face at least 3 times, 3 separate punches to the face in one incident. Per Staff B, they were down the hall by the resident's rooms. When queried how she became aware, Staff B explained she was down in the main room supervising everyone else, and heard Resident #17 yell, and was able to see Resident #22 punching her. Staff B explained she ran down there, and at that point Resident #22 backed off a little bit and came towards Staff B, and tried grabbing Staff B's arms. When queried about injuries and being punched in the face, Staff B explained Resident #17 had a bruise on the cheek. Per Staff B, Resident #17 was yelling for help and Resident #22 was in her room. Resident #17 was trying to get him (Resident #22) out of her room and Resident #22 attacked Resident #17. Per Staff B, they were right outside of her room.

Staff B explained she could not get anyone to answer when she used the walkie talkie to get ahold of other staff, called the DON who was not at the facility, who advised Staff B call 911. Per Staff B, when the cop showed up everyone else showed up. When queried if there was a nurse in the building when this occurred, Staff B responded the nurse was up front. When queried if there was paperwork filled out, Staff B responded, not to my knowledge. Staff B explained she did not fill anything out.

When queried about other altercations between Resident #22 and Resident #17, Staff B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600	Continued From page 25	F 600		

explained at least one more that she knew of. Per Staff B, Resident #22 grabbed Resident #17 by her arms and was starting to shake her. Staff B explained she was able to intervene for that one. Per Staff B, there was no documentation in the computer that said it had happened again.

When queried about Resident #22 and other residents/incidents, Staff B responded, basically like with all of them. Per Staff B, it didn't matter who it was, [Resident #22] was just aggressive. Per Staff B, it was more of like acting like going to do something and wouldn't follow through. When queried how the facility said to address such situations with Resident #22 and behaviors, Staff B responded to keep separate. When queried if that was possible to do, Staff B responded no. When queried if effective, Staff B responded no. Staff B was queried if management asked her any questions about what she had seen, or anything like that. Staff B responded, no, When queried if direct witness to both incidents, Staff B confirmed she was.

b. Resident #22 and Resident #11:

Review of the MDS assessment for Resident #11 dated 6/1/24 revealed the resident scored 13 out of 15 on a BIM's exam, which indicated intact cognition.

Review of the Care Plan for Resident #11 dated 3/20/24 revealed, [Resident #11] has a psychosocial well-being problem r/t (related to) lack of acceptance to current condition, Recent Admission. The Intervention dated 3/5/24 revealed, when conflict arises, remove me to a calm safe environment and allow to vent/share

F 600

Continued From page 26

feelings.

The Incident Report for Resident #22 dated 6/21/24 at 8:16 PM revealed, Did not see incident, was told by staff, then did interviews. Resident was getting in cupboards and fridge in unit, another resident told him "YOU CANT BE IN THERE" he continues to get in cupboards, other resident said again "I SAID YOU CANT GET IN THERE" [Resident #22] turned around and tried to close fist hit other resident in the face she grabbed his arm so he did not strike her, then he attempted to strike her with other arm, she grabbed and held both arms so he could not hit her while she yelled for help.

The Incident Note dated 6/21/24 at 8:21 PM present in Resident #22's Progress Notes revealed, resident on resident incident, this resident attempted to hit another resident, resident he tried to hit grabbed his forearms and yelled for help, CNA (Certified Nursing Assistant) [name redacted] helped, residents separated, interviews preformed, seems no staff present for actual altercation, in another residents room who is a 2 assist with incontinence. Came out to see [Resident #11] holding this resident's forearms. Stating he tried to hit her because he was getting in fridge and cupboards, which is not to happen, she said something, he tried to hit her, she stopped him. This resident been prone to violence recently, does not like redirection in any way, or has violent outbursts. PCP (Primary Care Physician) called order lorazepam 2mg/ml (milligram/milliliter):give 2mg (milligram) IM STAT NOW, then change to lorazepam intensol 2m/ml PO (per oral) Q4hrs (every four hours)(pharm said IM (intramuscular) hard to obtain) for agitation and aggression. DON notified, she was

F 600

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 27	F 600		

to call ADMIN. Attempted to call POA left VM (voicemail) to return call to facility. After giving IM Ativan (which he was happy and excited to get a shot? he was ready for bed, no issues directing him to bed, this nurse did 15min checks over an hr (hour), no issues.

The Behavior Note present in Resident R#11's record dated 6/21/24 at 8:31 PM revealed, in part, CNA's in a 2 A room d/t (due to) incontinence, so this resident took it upon herself to stop other residents [Initials Redacted] and [Initials Redacted] left without issue. [Initials matching Resident #22] did not and swung around and attempted to close fist strike her in face, she stopped him and held his arms till CNA came, scared if she let go he would hit her. Told resident in normal circumstances help is appreciated, but to not engage with other residents, find staff.

The Health Status Note dated 6/22/24 at 11:00 AM revealed, in part, questioned [Resident #11] regarding the situation she had with another resident and [Resident #11] was happy to be interviewed/assessed. She stated the make pt was trying to find food in the refrigerator and she yelled at him to get out of the fridge. When the male pt would not, she got up from her recliner in the common room and walked over to him, admitting she was very close to his face, and she yelled at home again. Male pt became upset and attempted to hit [Resident #11], [Resident #11] then grabbed his arm hard enough that she left marks on his arm.

The Behavior Note in Resident #22's record dated 6/25/24 at 1:12 PM revealed, res continues to get aggressive w/ (with) some res et staff. verbally disagreeing w/ another res this shift. Res

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET** **DONNELLSON, IA 52625**

(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 600		F 600		

Continued From page 28
is not easily redirected once he begins negative behavior.

Review of the Progress Note dated 6/26/24 at 11:00 PM for Date of Service 6/27/24 revealed, He continues to have some intermittent aggressive behaviors.

c. Resident #22 and Resident #24:

Review of the MDS assessment for Resident #24 dated 7/18/24 revealed the resident scored 2 out of 15 on a BIMs exam, which indicated severely impaired cognition. Per this assessment, the resident had other behavioral symptoms not directed towards others, which put the resident at significant risk for physical illness or injury.

Review of the Incident Report for Resident #22 dated 7/31/24 at 1:50 PM revealed, called to unit because of an altercation between resident and another resident. the CNA heard the residents and went to investigate the resident was wind milling his arms in attempt to hit the other resident. ([Resident #24]) was the other resident who only put his arms up to defend himself. CNA states that He ([Resident #22]) may have grazed the other resident. neither resident has marks or injuries et (and) they were easily redirected. Immediate action taken revealed, separated the residents.

On 8/19/24 at 12:05 PM, Resident #24 observed present at the table in the dementia unit of the facility. The resident had food in front of him, and was eating.

On 8/21/24 at 2:34 PM, Staff G, CNA, explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600		F 600		

Continued From page 29

Resident #22 had a lot of behaviors and other staff can be more troublesome. Staff G explained it depended on the day and how feeling. If feeling bad, quiet for the most part, and if normal self could be very, very aggressive. Staff G explained if the resident refused to try to get changed, get up, would have to wait till Resident #22's time. Staff G explained if the resident was bothered and did not want to be bothered, the resident would cuss at you. Staff G explained she was pretty sure staff told her that the resident got in a fight with [Resident #17]. Staff G then explained, him [Resident #22] and [Resident #24] had gotten into it before. Per Staff G, if went in and tried to change [other resident], Resident #22 would tell you to get the F out.

Staff G explained the following about a resident to resident incident: Per Staff G, Resident #22 was in Resident #24's room, Staff G went over there to get him out and redirect him out, he got very upset, went back, and Staff G explained when she was the only CNA back there it was very hard to keep an eye on every single resident there. Staff G explained Resident #22 swinging arms.

On 8/21/24 at 2:48 PM during an interview with Staff I, CNA, Staff I explained she had heard of Resident #22 having behaviors, and personally she had not had a lot of behaviors out of him (Resident #22). Per Staff I, she had asked the resident not to cuss, and if in pain would act out/get mad, couldn't tell what was going on. Staff I explained the following between Resident #22 and Resident #17: Have had to separate the two a couple times. She (Resident #17) would grab his (Resident #22's) arm, he would tell her (Resident #17) to get the F away from him. [Resident #17] would grab his (Resident #22's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600		F 600		

Continued From page 30

arm), and he would be like leave me the F alone, not going anywhere with you.

On 8/21/24 at 4:22 PM, Staff M, Licensed Practical Nurse (LPN) explained the following about Resident #22: Per Staff M, she was not sure if the resident spoke English. Staff M explained she had asked if needed a translator, and tried to use [redacted translating method]. Per Staff M, for the longest time the resident said following: Yes, no, [Expletive redacted] you, [Expletive redacted] you too. Staff M described the following about the incident between Resident #22 and Resident #11: Per Staff M, she thought she was there and didn't see it. Staff M explained she received a call, finally got back there, Resident #22 was trying to get in the fridge, and Resident #11 telling no. Resident #11 grabbed him on the arms, held him and yelled for help. Staff M explained she was there in the building and hadn't been back there to pass meds yet. Staff M explained Resident #22 attached one of the CNAs. Per Staff M, resident had been sent out the night before, they didn't do anything, and gave IM (intramuscular) Ativan. Staff M explained she heard screaming, muffled, and Resident #22 had the staff member cornered hitting her over the head with a wet floor sign.

On 8/22/24 at 12:36 PM, Staff E, former Director of Nursing (DON) explained the following between Resident #22 and Resident #17: Staff E explained Resident #17 kept going through Resident #22's belongings in the closet. Per Staff E, that was common for the resident, and explained the resident used to set up a garage sale two days a week. Per the former DON, the resident was very hard to redirect and knew redirected many, many times. Staff E explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 31	F 600		

Resident #22 said get out of my stuff, get out of my room, and Resident #22 got upset, held her (Resident #17) against the wall and hit her across the face. Per Staff E, had to call law enforcement more than one time on Resident #22, and Resident #17 did this and won't stop. Per the DON, an incident report was done and risk management. Staff E further explained Resident #22 was sent out more than one time for violent episode. When queried if she was in the building during the occurrence, Staff E responded she did not remember, he (Resident #22) had had so many incidents. Staff E explained the resident really had trouble keeping his temper under control, and that was why the resident was no contact with family as beat all of them up.

Staff E further explained when the resident (Resident #22) had his fifth violent episode the resident was at the hospital, and said he cannot keep beating people up. Per Staff E, at that time the resident viciously attacked a staff member, had beat her over the head with a floor sign, was not the flat part of it (sign), and was the folding part of it. Per Staff E, at that point they had talked about it, and said Resident #22 could not stay here. Staff E explained tried to talk to the Power of Attorney about it, who said there had to be a two weeks' notice given.

Staff E explained the resident ended up coming back. Per Staff E, when got [Resident #22] she (Staff E) personally read approved Resident #22 to come to facility. Per Staff E, the resident was at the hospital 280 days and in [other state redacted]. Staff E further explained she read the 80 pages and thought there was not a lot of info. Per Staff E, [another staff member name redacted] looked after the second violent episode,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600	Continued From page 32	F 600		

and found out the hospital withdrew weeks of documentation (violent outburst), and found out way after the fact that the resident violent. Per Staff E, by that time always having two people in the back, and if one had to do patient care one had to be there watching the hallways. Staff E explained now could kind of predict when the resident waving his hand or no, no, no, was ramping up.

On 8/28/24 at 8:03 AM, the Interim Director of Nursing (DON) present at the time of the survey explained the following: she was not aware of resident to resident with Resident #22 or the history. The Interim DON explained she knew had been issues with staff sometimes and to leave the resident alone.

The policy titled Exploitation; Abuse Prevention dated 10/2023 documented the facility has zero tolerance of abuse of any type or manner and will address accordingly. The policy included:
a. Policies to prevent abuse and actions to reduce the potential for abuse, mistreatment and neglect of residents.
b. The components include identification, investigation, reporting, training, protection, screening and prevention.

3. The Minimum Data Set (MDS), dated 5/10/24, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. MDS indicated Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600	Continued From page 33	F 600		

#20 had disorganized thinking and verbal behaviors directed towards others. Resident #20 able to transfer and ambulate independently throughout facility. Diagnoses included: non-Alzheimer's dementia, frontotemporal neurocognitive disorder, and insomnia. Resident #20 required antipsychotic and antidepressant medications on a daily basis.

The Care Plan, revised on 8/04/24, revealed Resident #20 had memory impairment due to dementia and resided in secured unit due to frontotemporal neurocognitive disorder. Resident #20 had behaviors that included hallucinations, wandering, inappropriate voiding, and episodes of delirium. Care Plan indicated goals for Resident #20 included having minimal complications from residing in secure unit and safety will be maintained through the review date. Interventions included:
1. Observations for changes in mood or behaviors.
2. Psychiatric services as indicated.
3. Distract Resident #20 from wandering as able by offering pleasant diversions, structured activities, food, conversation, television, book.
4. Intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, and remove from situation to alternate location as needed.

Review of Nursing Progress Notes, revealed the following entries:
a. On 1/20/24 at 3:10 AM, Resident #20 told staff she was scared to sleep in her room due to that man, and instead sleeping in unit common area recliner.
b. On 2/09/24 at 7:30 PM, another resident asked Resident #20 to sit on his lap, Resident #20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600		F 600		

Continued From page 34

started to pull the front of her pants down almost exposing pubic area but easily redirected. Nurse noted Resident #20 liked to be helpful and though she worked at facility.
c. On 3/28/24 at 4:13 PM, documentation revealed that Resident #20 had complained of bloating and nausea, note indicated resident had bowel movement 2 days ago and had her menstrual cycle 3 months ago, Nurse Practitioner was notified with no new orders.
d. On 4/19/24 at 10:54 AM, Resident #20 moved rooms due to wandering in and refusing to leave room 10. Note revealed Resident #20 refused to reenter previous room, had been acting out, and urinating on other beds.

On 8/21/24 at 11:09 AM, Staff B, Certified Nursing Assistant (CNA), revealed that she had heard Resident #18 had been found in Resident #20's bed on night shift, unknown date. Staff B reported that nurses had been concerned there at been sexual relations between the residents and was instructed to keep an eye on these two residents. Staff B additionally revealed that she had not observed Resident #20 to have disrobing behaviors but had witnessed Resident #18 touching himself on one occasion and required staff redirection.

On 8/21/24 at 3:02 PM, Staff I, CNA, reported she had not ever witnessed Resident #18 and Resident #20 together, but had heard that Resident #18 would go into Resident #20's room.

On 8/21/24 at 3:33 PM, Staff M, Licensed Practical Nurse (LPN), revealed that Resident #20 and a male Resident #18 had been found touching each other approximately 6 months ago and that nothing had been done about it. LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 35	F 600		

stated that Resident #18 had then been put on the medication Sametidine, to help with sexual behaviors. Staff M stated she had worked a night shift and received a written report from CNA that Resident #18 and Resident #20 had been found together in Resident #20's room, Staff M informed that she text the Director of Nursing (DON) and put the written report in DON's box. Staff M revealed that nursing staff had concern that Resident #18 was pregnant as her belly had been growing and that nurses and Administrator decided to perform a pregnancy test on Resident #18.

On 8/22/24 at 9:15 AM, Staff L, Regional Nurse Consultant, revealed that she had heard about a concern that Resident #18 had been pregnant and stated Administrator, Staff N, was aware and had an investigation file on this concern and that Corporate Office had also been involved. Staff L stated that due to Resident #18 gaining weight a rumor had been started that she was pregnant as a result of Resident #18 being found in her room. Staff L informed that she became aware by former DON, Staff AA, unsure of date, approximately February of 2024, that when the residents were found together, both had clothes on, also that they had been together for approximately 2 minutes, then separated by staff. Staff L recalled that Staff AA told her a pregnancy test was performed with negative results, Staff L unsure if family or Provider had been involved for pregnancy test order. Staff L revealed that Staff AA and Staff N were supposed to get together an interview staff on concern but unsure if interviews occurred.

On 8/22/24 at 12:04 PM, Staff E, a former DON, stated within a couple of weeks starting position

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 600	Continued From page 36	F 600		

she had been notified that nurses wanted to do a pregnancy test on Resident #20 as they suspected something happened between her and Resident #18. Staff E revealed that the DON prior to her start, Staff AA, had called Resident #18's Provider for a pregnancy test and had been denied order. Staff E stated, Staff N, former Administrator, had been aware of pregnancy test performed on Resident #20. Staff E stated she had been told the results were negative.

On 8/26/24 at 2:25 PM, Staff Q, LPN, revealed there had been a concern that Resident #20's belly had gotten bigger, hadn't had menstrual cycle for 3 months, and other nurses had indicated something happened on the unit. Staff Q revealed she had sent fax to Resident #20's Provider in request for pregnancy test but did not get a response. Staff Q stated that herself and another nurse bought a pregnancy test, collected a urine specimen from Resident #20, and dipped test in urine, to "get everyone to shut up about it".

On 8/26/24 at 2:42 PM, Staff AA, former DON, reported being aware of an incident in common area in which Resident #20 had dropped her pants in front of Resident #18, and Resident #18 began to touch himself in a sexual manner, a CNA saw, covered Resident #20, and directed Resident #18 to his room. Staff AA stated being aware of another incident in which Resident #20 had been in bed and Resident #18 was in her doorway, both residents were clothed and a CNA redirected Resident #18 back to his room. Staff AA revealed there had been rumors that something occurred between Resident #20 and Resident #18, however, nothing was witnessed. Staff AA stated that Resident #18 had been started on medication Sametidine the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 600	Continued From page 37 incident occurred in common area. Staff AA reported that Staff N, former Administrator, and herself were supposed to go together and interview staff about concern for Resident #20 pregnancy but that Staff N stated she was looking in to it, so did not pursue own investigation. On 8/26/24 at 4:47 PM, Staff N, former Administrator, reported being aware that Resident #20 and Resident #18 were found together and staff believed something of a sexual manner happened between the two residents, but indicated this had been a rumor. Staff N stated former DON, Staff AA, told her nothing had been witnessed and there was no evidence of this happening. Staff N informed that she was not worried about occurrence between the 2 residents because the DON, Staff AA, was not worried about it. Staff N stated she had been aware that staff wanted to get a pregnancy test order, but had not been aware that a pregnancy test had been performed until afterwards when she was notified of the negative result. Review of Resident #20's Electronic Health Records (EHR) lacked incident report or follow up documentation related to alleged resident to resident sexual abuse. Review of Facility Reported Incidents lacked report of alleged resident to resident sexual abuse that involved Resident #20.	F 600		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 609	Continued From page 38	F 609		

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and clinical record review, the facility failed to ensure all allegations of abuse were reported to the State Agency. Resident #77 sustained physical and mental abuse on or about 8/11/24 that was brought to the attention of facility management staff at that time.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 11, 2024 on August 22, 2024 at 3:15 p.m. As of the exit date, August 28, 2024, the immediacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 609		F 609		

Continued From page 39
was not removed.

The facility identified a census of 31 residents.

Findings Include:

During an interview on 8/19/24 at 3:21 p.m., Resident #77 stated the staff dropped her during a transfer after she was admitted and expressed fear of being dropped again.
During an interview on 8/22/24 at 10:24 a.m. Staff K, CNA stated that when she arrived for the 2p-10 p.m. shift 8/11/24 she was confronted by Staff D. Staff K stated she thought Staff D was a CNA, as this was the first time meeting them. Staff K stated Staff D was very aggressive with Resident #77, stating if she wanted to go home, she had to get up and walk. Resident #77 stated she could not stand and walk. Staff K stated Staff D told her to grab Resident #77's arm to sit her up and stand her. Staff K stated Resident #77 could not stand and it was like "dead weight" without a gait belt. Staff K stated she told Staff D that she could not force someone to do something they didn't want to, but Staff D stated she was out of patience and spun Resident #77 into the wheelchair, pushed her to the bathroom, and forced Resident #77 to the toilet by grabbing her arm to stand her. Staff K stated Resident #77 continued to tell Staff D that she could not stand. Staff K stated after 2 minutes of Resident #77's inability to void, Staff D stated that she had to go home, instructed Staff K to grab her arm, pivoted and sat the resident in the wheelchair and wheeled her to the bedside. Staff K stated Staff D had her back to the bed and took Resident #77 by the arm to stand her and the resident went to the floor with her feet straight out in front of her. Staff K stated her training taught her to get the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 609	Continued From page 40	F 609		

nurse and a mechanical lift to help the resident back to bed after a fall. Staff K stated that Staff D said "No, grab her arm and lift her". Staff K stated they were able to stand Resident #77, then Staff D spun the resident who fell onto Staff D and into the bed. Staff K stated the door opened and the DON stepped into the room, then stepped out and Staff J, CNA entered the room and assisted to get Resident #77 into the bed. Staff K stated she provided incontinent care and apologized to Resident #77. Staff K stated she went to the nurses station, reported to the nurse and since the DON and Staff D left the building, Staff K was instructed to report to the Administrator who was in the dementia unit. Staff K stated the Administrator instructed her to write a statement and place it on her desk.

A document dated 8/11/24 signed by Staff K, Certified Nursing Assistant (CNA) written on 8/11/24 at 2:44 p.m. stated that she was instructed by Staff D, Social Services/Activity Director (SS/AD) to assist Resident #77 to the toilet. A report on 8/10/24 instructed Staff K to utilize a mechanical lift for Resident #77 and Staff D stated only 1 person was needed and she could stand, pivot and assist the resident to the toilet. Resident #77 stated she could not stand. Staff D instructed Staff K to grab Resident #77 by the arm, stand her and pivot her to the wheelchair. Staff D wheeled resident to the bathroom, instructed her to stand using the grab bar, and when she could not, Staff D instructed Staff K to grab her arm, put her on the toilet, then returned the resident to the wheelchair and her bedside. Resident was lowered to the floor. Staff D instructed Staff K to help lift Resident #77 to the bed.

F 609 Continued From page 41 F 609

A review of the facility reported incidents, on or about 8/11/24, lacked a report to the Department of Inspections, Appeals, and Licensing (DIAL) regarding this incident.

The policy titled Exploitation; Abuse Prevention dated 10/2023 revealed:
a. Prevent abuse and actions to reduce the potential for abuse, mistreatment and neglect of residents.
b. The components include identification, investigation, reporting, training, protection, screening and prevention.

During an interview on 8/22/24 at 2:40 p.m. the Administrator denied knowledge of the incident that occurred on 8/11/24 involving Resident #77. When the surveyor asked about the statement provided by Staff K, CNA that was sitting physically on the desk in the Administrators office next to the surveyor, the Administrator stated she had found the statement at the nurses station and had not read it yet. The Administrator stated there was no investigation and it was not reported as an abuse allegation to the DIAL.

2. The Minimum Data Set (MDS), dated 5/10/24, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. MDS indicated Resident #20 had disorganized thinking and verbal behaviors directed towards others. Resident #20 able to transfer and ambulate independently throughout facility. Diagnoses included: non-Alzheimer's dementia, frontotemporal neurocognitive disorder, and insomnia. Resident #20 required antipsychotic and antidepressant medications on a daily basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 609		F 609		

Continued From page 42

The Care Plan, revised on 8/04/24, revealed Resident #20 had memory impairment due to dementia and resided in secured unit due to frontotemporal neurocognitive disorder. Resident #20 had behaviors that included hallucinations, wandering, inappropriate voiding, and episodes of delirium.

Review of Nursing Progress Notes, revealed the following entries:
a. On 1/20/24 at 3:10 AM, Resident #20 told staff she was scared to sleep in her room due to that man, and instead sleeping in unit common area recliner.
b. On 2/09/24 at 7:30 PM, another resident asked Resident #20 to sit on his lap, Resident #20 started to pull the front of her pants down almost exposing pubic area but easily redirected. Nurse noted Resident #20 liked to be helpful and though she worked at facility.

On 8/21/24 at 11:09 AM, Staff B, Certified Nursing Assistant (CNA), revealed that she had heard Resident #18 had been found in Resident #20's bed on night shift, unknown date. Staff B reported that nurses had been concerned there at been sexual relations between the residents and was instructed to keep an eye on these two residents.

On 8/21/24 at 3:02 PM, Staff I, CNA, reported she had not ever witnessed Resident #18 and Resident #20 together, but had heard that Resident #18 would go into Resident #20's room.

On 8/21/24 at 3:33 PM, Staff M, Licensed Practical Nurse (LPN), revealed that Resident #20 and a male Resident #18 had been found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 609	Continued From page 43	F 609		

touching each other approximately 6 months ago and that nothing had been done about it. Staff M stated she had worked a night shift and received a written report from CNA that Resident #18 and Resident #20 had been found together in Resident #20's room, Staff M informed that she text the Director of Nursing (DON) and put the written report in DON's box.

On 8/22/24 at 9:15 AM, Staff L, Regional Nurse Consultant, revealed that she had heard about a concern that Resident #18 had been pregnant and stated Administrator, Staff N, was aware and had an investigation file on this concern and that Corporate Office had also been involved. Staff L informed that she became aware by former DON, Staff AA, unsure of date, approximately February of 2024, that when the residents were found together, both had clothes on, also that they had been together for approximately 2 minutes, then separated by staff.

On 8/22/24 at 12:04 PM, Staff E, a former DON, stated within a couple of weeks starting position she had been notified that nurses wanted to do a pregnancy test on Resident #20 as they suspected something happened between her and Resident #18.

On 8/26/24 at 2:25 PM, Staff Q, LPN, revealed there had been a concern that Resident #20's belly had gotten bigger, hadn't had menstrual cycle for 3 months, and other nurses had indicated something happened on the unit.

On 8/26/24 at 2:42 PM, Staff AA, former DON, reported being aware of an incident in common area in which Resident #20 had dropped her pants in front of Resident #18, and Resident #18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 609	Continued From page 44 began to touch himself in a sexual manner, a CNA saw, covered Resident #20, and directed Resident #18 to his room. On 8/26/24 at 4:47 PM, Staff N, former Administrator, reported being aware that Resident #20 and Resident #18 were found together and staff believed something of a sexual manner happened between the two residents, but indicated this had been a rumor. Staff N stated former DON, Staff AA, told her nothing had been witnessed and there was no evidence of this happening. Staff N informed that she was not worried about occurrence between the 2 residents because the DON, Staff AA, was not worried about it. Review of Resident #20's Electronic Health Records (EHR) lacked incident report or follow up documentation related to alleged resident to resident sexual abuse. Review of Facility Reported Incidents lacked report of alleged resident to resident sexual abuse that involved Resident #20 to the State Agency.	F 609		
F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 610		F 610		

Continued From page 45
investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and clinical record review, the facility failed to take measures to fully investigate allegations of abuse and failed to prevent and protect residents from further potential abuse during the investigation. Resident #77 sustained physical and mental abuse on or about 8/11/24 that was brought to the attention of facility management staff at that time.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 11, 2024 on August 22, 2024 at 3:15 p.m. As of the exit date, August 28, 2024, the immediacy was not removed.

The facility identified a census of 31 residents.

Findings Include:

During an interview on 8/19/24 at 3:21 p.m., Resident #77 stated the staff dropped her during a transfer after she was admitted and expressed fear of being dropped again.
During an interview on 8/22/24 at 10:24 a.m. Staff K, CNA stated that when she arrived for the 2p-10 p.m. shift she was confronted by Staff D. Staff K stated she thought Staff D was a CNA, as this was the first time meeting her. Staff K stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 610	Continued From page 46 Staff D was very aggressive with Resident #77, stating if she wanted to go home, she had to get up and walk. Resident #77 stated she could not stand and walk. Staff K stated Staff D told her to grab Resident #77's arm to sit her up and stand her. Staff K stated Resident #77 could not stand and it was like "dead weight" without a gait belt. Staff K stated she told Staff D that she could not force someone to do something they did not want to, but Staff D stated she was out of patience and spun Resident #77 into the wheelchair, pushed her to the bathroom, and forced Resident #77 to the toilet by grabbing her arm to stand her. Staff K stated Resident #77 continued to tell Staff D that she could not stand. Staff K stated after 2 minutes of Resident #77's inability to void, Staff D stated that she had to go home, instructed Staff K to grab her arm, pivoted and sat the resident in the wheelchair, and wheeled her to her bedside. Staff K stated Staff D had her back to the bed and took Resident #77 by the arm to stand her and the resident went to the floor with her feet straight out in front of her. Staff K stated her training taught her to get the nurse and a mechanical lift to help the resident back to bed after a fall. Staff K stated that Staff D said "No, grab her arm and lift her". Staff K stated they were able to stand Resident #77, then Staff D spun the resident who fell onto Staff D and into the bed. Staff K stated the door opened and the DON stepped into the room, then stepped out and Staff J, CNA entered the room and assisted to get Resident #77 into the bed. Staff K stated she provided incontinent care and apologized to Resident #77. Staff K stated she went to the nurses station, reported to the nurse and since the DON and Staff D left the building, Staff K was instructed to report to the Administrator who was in the dementia unit. Staff K stated the Administrator instructed her to write	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 610		F 610		

Continued From page 47
a statement and place it on her desk.

A document dated 8/11/24 signed by Staff K, Certified Nursing Assistant (CNA) written on 8/11/24 at 2:44 p.m. stated that she was instructed by Staff D, Social Services/Activity Director (SS/AD) to assist Resident #77 to the toilet. A report on 8/10/24 instructed Staff K to utilize a mechanical lift for Resident #77 and Staff D stated only 1 person was needed and she could stand, pivot and assist the resident to the toilet. Resident #77 stated she could not stand. Staff D instructed Staff K to grab Resident #77 by the arm, stand her and pivot her to the wheelchair. Staff D wheeled the resident to the bathroom, instructed her to stand using the grab bar, and when she could not, Staff D instructed Staff K to grab her arm, put her on the toilet, then returned the resident to the wheelchair and her bedside. Resident was lowered to the floor during the transfer. Staff D instructed Staff K to help lift Resident #77 to the bed.

A review of the facility reported incidents, on or about 8/11/24, lacked a report regarding this incident to the Department of Inspections, Appeals and Licensing (DIAL).

The policy titled Exploitation; Abuse Prevention dated 10/2023 revealed:
a. Prevent abuse and actions to reduce the potential for abuse, mistreatment and neglect of residents.
b. The components include identification, investigation, reporting, training, protection, screening and prevention.

During an interview on 8/22/24 at 2:40 p.m. the Administrator denied knowledge of the incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 610	Continued From page 48	F 610		

that occurred on 8/11/24 involving Resident #77. When the surveyor asked about the statement provided by Staff K, CNA that was sitting physically on the desk in the Administrators office next to the surveyor, the Administrator stated she had found the statement at the nurses station and had not read it yet. The Administrator stated there was no investigation and it was not reported as an abuse allegation to the DIAL.

2. The Minimum Data Set (MDS), dated 5/10/24, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. MDS indicated Resident #20 had disorganized thinking and verbal behaviors directed towards others. Resident #20 able to transfer and ambulate independently throughout facility. Diagnoses included: non-Alzheimer's dementia, frontotemporal neurocognitive disorder, and insomnia. Resident #20 required antipsychotic and antidepressant medications on a daily basis.

The Care Plan, revised on 8/04/24, revealed Resident #20 had memory impairment due to dementia and resided in secured unit due to frontotemporal neurocognitive disorder. Resident #20 had behaviors that included hallucinations, wandering, inappropriate voiding, and episodes of delirium.

Review of Nursing Progress Notes, revealed the following entries:
a. On 1/20/24 at 3:10 AM, Resident #20 told staff she was scared to sleep in her room due to that man, and instead sleeping in unit common area recliner.
b. On 2/09/24 at 7:30 PM, another resident asked Resident #20 to sit on his lap, Resident #20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 610		F 610		

Continued From page 49

started to pull the front of her pants down almost exposing pubic area but easily redirected. Nurse noted Resident #20 liked to be helpful and though she worked at facility.
c. On 3/28/24 at 4:13 PM, documentation revealed that Resident #20 had complained of bloating and nausea, note indicated resident had bowel movement 2 days ago and had her menstrual cycle 3 months ago, Nurse Practitioner was notified with no new orders.
d. On 4/19/24 at 10:54 AM, Resident #20 moved rooms due to wandering in and refusing to leave room 10. Note revealed Resident #20 refused to reenter previous room, had been acting out, and urinating on other beds.

On 8/21/24 at 11:09 AM, Staff B, Certified Nursing Assistant (CNA), revealed that she had heard Resident #18 had been found in Resident #20's bed on night shift, unknown date. Staff B reported that nurses had been concerned there at been sexual relations between the residents and was instructed to keep an eye on these two residents.

On 8/21/24 at 3:02 PM, Staff I, CNA, reported she had not ever witnessed Resident #18 and Resident #20 together, but had heard that Resident #18 would go into Resident #20's room.

On 8/21/24 at 3:33 PM, Staff M, Licensed Practical Nurse (LPN), revealed that Resident #20 and a male Resident #18 had been found touching each other approximately 6 months ago and that nothing had been done about it. LPN stated that Resident #18 had then been put on the medication Sametidine, to help with sexual behaviors. Staff M stated she had worked a night shift and received a written report from CNA that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 610		F 610		

Continued From page 50

Resident #18 and Resident #20 had been found together in Resident #20's room, Staff M informed that she text the Director of Nursing (DON) and put the written report in DON's box. Staff M revealed that nursing staff had concern that Resident #18 was pregnant as her belly had been growing and that nurses and Administrator decided to perform a pregnancy test on Resident #18.

On 8/22/24 at 9:15 AM, Staff L, Regional Nurse Consultant, revealed that she had heard about a concern that Resident #18 had been pregnant and stated Administrator, Staff N, was aware and had an investigation file on this concern and that Corporate Office had also been involved. Staff L stated that due to Resident #18 gaining weight a rumor had been started that she was pregnant as a result of Resident #18 being found in her room. Staff L informed that she became aware by former DON, Staff AA, unsure of date, approximately February of 2024, that when the residents were found together, both had clothes on, also that they had been together for approximately 2 minutes, then separated by staff. Staff L recalled that Staff AA told her a pregnancy test was performed with negative results, Staff L unsure if family or Provider had been involved for pregnancy test order. Staff L revealed that Staff AA and Staff N were supposed to get together an interview staff on concern but unsure if interviews occurred.

On 8/22/24 at 12:04 PM, Staff E, a former DON, stated within a couple of weeks starting position she had been notified that nurses wanted to do a pregnancy test on Resident #20 as they suspected something happened between her and Resident #18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 610	Continued From page 51	F 610		

On 8/26/24 at 2:25 PM, Staff Q, LPN, revealed there had been a concern that Resident #20's belly had gotten bigger, hadn't had menstrual cycle for 3 months, and other nurses had indicated something happened on the unit.

On 8/26/24 at 2:42 PM, Staff AA, former DON, reported being aware of an incident in common area in which Resident #20 had dropped her pants in front of Resident #18, and Resident #18 began to touch himself in a sexual manner, a CNA saw, covered Resident #20, and directed Resident #18 to his room. Staff AA stated being aware of another incident in which Resident #20 had been in bed and Resident #18 was in her doorway, both residents were clothed and a CNA redirected Resident #18 back to his room. Staff AA revealed there had been rumors that something occurred between Resident #20 and Resident #18, however, nothing was witnessed. Staff AA stated that Resident #18 had been started on medication Sametidine the day incident occurred in common area. Staff AA reported that Staff N, former Administrator, and herself were supposed to go together and interview staff about concern for Resident #20 pregnancy but that Staff N stated she was looking in to it, so did not pursue own investigation.

On 8/26/24 at 4:47 PM, Staff N, former Administrator, reported being aware that Resident #20 and Resident #18 were found together and staff believed something of a sexual manner happened between the two residents, but indicated this had been a rumor. Staff N stated former DON, Staff AA, told her nothing had been witnessed and there was no evidence of this happening. Staff N informed that she was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 610 Continued From page 52 F 610

worried about occurrence between the 2 residents because the DON, Staff AA, was not worried about it. Staff N stated she had been aware that staff wanted to get a pregnancy test order, but had not been aware that a pregnancy test had been performed until afterwards when she was notified of the negative result.

Review of Resident #20's Electronic Health Records (EHR) lacked incident report or follow up documentation related to alleged resident to resident sexual abuse, interventions taken to maintain sepearation, and no comprehensive abuse investigation completed.

F 622 SS=D Transfer and Discharge Requirements F 622
CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 622		F 622		

Continued From page 53

submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 622		F 622		

Continued From page 54

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility policy review, the facility failed to complete discharge documentation or communication to receiving providers for 2 out of 2 residents reviewed for transfer requirements(Resident#22, #11). The facility reported a census of 31 residents.

Findings include:

1. Review of the Admission Minimum Data Set (MDS) assessment for Resident #22 dated 6/18/24 revealed the resident scored 99 on a Brief Interview for Mental Status (BIMS) exam,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165260	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 622	Continued From page 55	F 622		

which indicated the resident was unable to complete the interview.

The Communication with Family Note dated 7/26/24 at 2:22 PM revealed, Called POA (Power of Attorney) I spoke to his social worker she had me send him out since he is not a DNR (Do Not Resuscitate). Admonition is to call Monday to get the DNR process started.

Review of the resident's Progress Notes lacked assessment of the resident, documentation of clinical condition, or the reason the resident was sent out. Progress notes lacked what time the resident left the facility, what information was sent with the resident, and lacked information about notifications made related to hospital transfer.

The Health Status Note dated 7/26/24 at 5:52 PM revealed, Dr. [Name Redacted] called from [Hospital Name] wanting to know res med list. shortly after [name redacted] from [hospital name] called they are sending res to [hospital name] d/t (due to) anemia et (and) a hemoglobin of 6.3. They attp to reach POA unsuccessfully this nurse was also unsuccessful.

2. Review of Resident #11's Minimum Data Set (MDS) assessment dated 6/1/24 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

On 8/26/24 at 9:48 AM, the Regional Vice President of Operations explained 13 residents would be transferred out to sister facilities, the only residents left would be in the closed unit, and could staff for that.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 622 Continued From page 56 F 622

It was noted at time of survey, Resident #11 did not reside on the dementia unit. Review of Resident #11's Progress Notes lacked when the resident had been transferred, and to which facility the resident had been transferred.

Review of a Facility Policy titled Documentation Standard, dated 7/1/24, revealed the following: Transfer Documentation includes MD (Medical Doctor) order for transfer; [electronic health record] transfer assessment; and List of medication; nursing note that includes notification of responsible party; Notification of Ombudsman.

F 636 SS=D Comprehensive Assessments & Timing
CFR(s): 483.20(b)(1)(2)(i)(iii) F 636

§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 636		F 636		

Continued From page 57

(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 636

Continued From page 58

and facility policy review, the facility failed to ensure completion of the Admission Minimum Data Set (MDS) assessment per required regulatory timeframe for one of one resident reviewed for timely admission MDS assessments (Resident #24). The facility reported a census of 31 residents.

Findings include:

1. Review of the census tab revealed Resident #24 admitted ot the facility 7/8/24.

Review of the Admission MDS assessment with Assessment Reference date 7/18/24 revealed a completion date of 7/29/24.

On 8/28/24 at 8:23 AM when queried if completion of MDS timely had been a concern, the Director of Nursing (DON) explained she assumed, did not really know, and explained when she took over she caught up. The current DON started 7/22, and explained she was pretty sure she'd completed the MDS discussed.

The Facility Policy titled RAI (Resident Assessment Instrument)/Care Plan Management, dated 10/23, revealed the following: The MDS is completed by the 14th day on all new admissions into the facility.

F 637 SS=D

Comprehensive Assessment After Signifcant Chg
CFR(s): 483.20(b)(2)(ii)

§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 637	Continued From page 59	F 637		

means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and facility policy review, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment completed timely after the resident admitted to hospice service for one of one resident reviewed for hospice services (Resident #8). The facility reported a census of 31 residents.

Findings include:

On 8/1/24 at 4:04 PM, review of the Minimum Data Set history for Resident #8 revealed the Significant Change MDS assessment with Assessment Reference Date (ARD) 8/2/24 revealed the MDS remained in progress.

Review of the Physician Order for Resident #8 revised on 7/9/24 revealed, [Hospice Company Name Redacted] consult for hospice care to help with pain control.

The Care Plan for Resident #8 initiated 7/11/24 revealed, [Resident #8] has accepted Hospice Care through [Name Redacted] for pain control.

On 8/28/24 at 8:23 AM during an interview with the Interim Director of Nursing (DON) about a significant change for resident on hospice, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET** **DONNELLSON, IA 52625**

(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 637	Continued From page 60 DON acknowledged would have 14 days to be completed. The Facility Policy titled RAI (Resident Assessment Instrument)/Care Plan Management, dated 10/23, revealed the following: A significant change MDS is completed when there is a significant change in status of a resident in two (2) or more areas that are unplanned and not self-limiting. In the case of a significant change, the resident is observed for a period of one (1) to fourteen (14) days depending on the clinical situation and severity of symptoms. If the change appears to be permanent, a complete MDS is completed by day fourteen (14), from the determination that a significant change has occurred.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and facility policy review the facility failed to ensure accurate coding of medications on the Minimum Data Set (MDS) assessment for one of one resident reviewed for MDS accuracy (Resident #11). The facility reported a census of 31 residents. Findings include: Review of Resident #11's Minimum Data Set (MDS) assessment dated 6/1/24 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 641	Continued From page 61	F 641		

intact cognition. Per this assessment, the resident had a diagnosis of schizoaffective disorder, bipolar type. Per this assessment, the resident received antipsychotics on a routine basis only.

The Care Plan dated 3/5/24, revised on 5/1/24 revealed, [Resident #11] uses psychotropic medications r/t (related to) Disease process Schizophrenia and Bipolar disorder.

The Physician Order dated 2/22/24 revealed, Chlorpromazine HCl Oral Tablet 200 MG (milligram), an antipsychotic medication, with directions to give 200 mg by mouth three times a day related to schizoaffective disorder, bipolar type.

The Physician Order dated 2/22/24 revealed, Chlorpromazine HCl Oral Tablet 50 MG with directions to give 50 mg by mouth as needed for agitation related to schizoaffective disorder, bipolar type one tab PO (per oral) bid (twice a day) prn (as needed) for agitation.

Review of Resident #11's Medication Administration Record (MAR) dated May 2024 revealed the resident received the PRN Chlorpromazine HCL Oral Tablet medication multiple times in the month.

On 8/28/24 during an interview with the Interim Director of Nursing (DON), the DON acknowledged if on PRN antipsychotics as well, should be on the MDS.

The Facility Policy titled RAI (Resident Assessment Instrument)/Care Plan Management, dated 10/23, revealed the following per the MDS Completion Section: The IDT members discuss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 641	Continued From page 62 and then document the most accurate, consistent coding information on the MDS.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure specialized services per the Preadmission Screening and Resident Review (PASARR) were included in the resident's Care Plan and follow Level II PASARR recommendations for one of one resident reviewed for PASARR (Resident #11). The facility reported a census of 31 residents. Findings include: Review of Resident #11's Minimum Data Set	F 644		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 644	Continued From page 63	F 644		

(MDS) assessment dated 6/1/24 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident had a diagnosis of schizoaffective disorder, bipolar type.

Review of the resident's PASARR dated 2/9/24 revealed Resident #11 had a Level II PASARR with short term stay approval. Per the PASARR Level II, the following specialized services were needed: Ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner, a crisis intervention/safety plan, a Power of Attorney, a referral for integrated home health, a referral or application for eligibility determination for Medicaid coverage including home and community based (HCBS) waivers, an occupational and physical therapy screening, and obtaining psychiatric/behavioral health treatment records. The resident required the following community placement supports: home health nurse and aide services.

The Care Plan dated 3/5/24, revised on 7/26/24, revealed, [Resident #11] wishes to move to another group home or live on her own. 7/25/24 [Resident #11] will be transferring soon to a group home with [Name Redacted]. The Intervention dated 3/5/24 revealed, PASSR has deemed it appropriate for me to be in a nursing home for 1 year.

The Care Plan for Resident #11 lacked a crisis intervention/safety plan, did not address a Power of Attorney for the resident, did not specify the resident's psychiatric services provider name, and lacked information about home and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 644 | F 644

Continued From page 64
community based service waiver.

Observation during time of survey revealed Resident #11 was independently ambulatory in the front (outside of the chronic confusion dementing illness) part of the facility.

On 8/28/24 at 8:50 AM, the Interim Director of Nursing (DON) explained PASARR Level II specialized services would be implemented by social services and was a team effort.

Review of the Facility Policy titled Preadmission Screening and Resident Review, dated August 2024, revealed, The outcome of the Level II evaluation confirms the need for placement in a skilled nursing facility and provides a set of service recommendations for providers to use in developing the individualized plan of care.

F 655 SS=D | F 655

Baseline Care Plan
CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 655 Continued From page 65 F 655

(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interviews, and policy review, the facility failed to develop a base line care plan within 48 hours that included instructions for staff to provide effective services and treatments for 2 of 7 newly admitted residents reviewed (Resident #77 & #78). The baseline care plan for Resident #77, admitted on 8/7/24, failed to provide direction for staff for transfers and the treatment of pain and the baseline care plan for Resident #78 failed to provide treatment directives for the surgical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ________ B. WING ________	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 655		F 655		

Continued From page 66
abdominal drains and the wound vac. The facility reported a census of 31 residents.

Findings include:

1. The Activity of Daily Living (ADL) assessment dated 8/7/24 for Resident #77 revealed total dependence on 2 staff for bed mobility, transfers and toileting.

The Baseline Care Plan dated 8/7/24 lacked direction for staff to address ADL's and pain. The care plan identified limited physical mobility due to weakness, totally dependent on (X) staff for walking and (X) staff for locomotion. The care plan did not address pain until 8/14/24 and directed staff to monitor pain.

During an interview on 8/19/24 at 3:21 PM, Resident # 77 stated when she was admitted on 8/7/24, the facility did not provide the pain medication she needed for her hips, back and knees. Resident #77 stated, "I cried and cried, it was the worst pain". Resident #77 stated the staff dropped her after she was admitted and expressed fear of being dropped again.

Progress notes on 8/8/24 and 8/9/24 for Resident #77 revealed she was lowered to the floor, two separate incidents, due to weakness and a mechanical lift was used to lift her from the floor.

A document dated 8/11/24 signed by Staff K, Certified Nursing Assistant (CNA) wrote on 8/11/24 at 2:44 p.m. that she was instructed by Staff D, Social Services/Activity Director (SS/AD) to assist Resident #77 to the toilet. A report on 8/10/24 instructed Staff K to utilize a mechanical lift for Resident #77 and Staff D stated only 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 655	Continued From page 67	F 655		

person was needed and she could stand, pivot and assist the resident to the toilet. Resident #77 stated she could not stand.

During an interview on 8/22/24 at 11:21 a.m. Staff E, former Director of Nursing stated Resident #77 was refusing to get out of bed on the day of admission due to pain and weakness and was a maximum assist of 2 persons with a mechanical lift as she could not bear weight.

2. During an observation on 8/19/24 at 3:39 p.m. Resident #78 had a surgical wound to her left side with a wound vac set on a continuous setting and 2 drains from the abdomen to bulbs with a scant amount of drainage on left and small amount on the right.

During an interview on 8/19/24 at 3:39 p.m. Resident #78 stated the wound vac dressing was scheduled to be changed that day and nursing had not completed that treatment.

During an interview on 8/20/24 at 1:13 p.m., Resident #78 stated the dressings for the wound vac and the drains were changed last Friday 8/16/24. Resident #78 stated, "They only empty the drainage about every 2 days and the doctor stated the drains can come out if I have 5 cc or less, so how do they know if it's 5 cc's or less daily if they don't empty them daily?"

The Physician's order for Resident #78 revealed:
a. wound vac on upper left flank change 3 times a weekly on Wednesday, Monday, Friday, setting at 125 mmHg suction, with foam dressings black and white.
b. Lack of an order for treatment for the abdominal drains (right and left) dressing change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 655	Continued From page 68	F 655		

nor when to empty.

The Treatment Administration Record for Resident #78 revealed:
a. The wound vac dressing was changed last on 8/16/24.
b. Lack of documentation of drainage from wound vac.
c. Lack of documentation for the right and left drains for a dressing change and measurement of drainage bulbs.

The Baseline Care Plan for Resident #78 identified:
a. The wound vac but failed to provide direction for nursing staff for dressing changes, the complications to monitor and the setting of the wound vac (continuous or intermittent).
b. The drains were to be flushed twice daily but failed to direct nursing staff to the type of flush, amount of flush, to monitor the output of the 2 surgical drains and when to change the dressings.

The policy titled RAI/Care Planning Management dated 10/2023 revealed:
a. The interim baseline care plan is developed within 48 hours of admission to the facility.
b. Based on resident needs identified in the admission nursing assessment, initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and other pertinent information.
c. Nursing admission assessments are completed during the admission process.
d. Admission orders for the care plan are verified with the attending physician by the licensed nurse conducting the admission.
e. Immediate resident needs are identified,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 655	Continued From page 69 effective interventions are implemented, and measurable goals are established.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise the Care Plan when a resident no longer resided on the dementia area of the facility and failed to ensure	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ___ B. WING ___	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 657		F 657		

Continued From page 70
the Care Plan included self-injurious and/or self-harm behaviors for three of sixteen residents reviewed for care plans (Resident #11, #23, #2). The facility reported a census of 31 residents.

Findings include:

1. Review of Resident #11's Minimum Data Set (MDS) assessment dated 6/1/24 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

The Care Plan for Resident #11 dated 3/20/24 revealed, [Resident #11] resides in the secure unit, due to DX (diagnosis) of dementia.

Review of the resident's clinical record revealed the resident no longer resided in the dementia area of the facility as of 7/14/24.

On 8/20/24 at 11:21 AM, Resident #11 was interviewed in their room, noted to not be in the secured part of the facility.

On 8/28/24 at 8:41 AM, the Interim Director of Nursing (DON) explained they had not gotten to do anything with care plans yet. When queried if the care plan should say resident on dementia unit if not, the DON responded no.

The Facility Policy titled RAI (Resident Assessment Instrument)/Care Plan Management, dated 10/23, revealed the following: Care plans are to be updated in an acute situation when identified, such as falls, falls with injury, new skin alterations, worsening skin conditions, behaviors, resident events, weight loss, infections, uncontrolled pain, allegations of abuse and other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 657	Continued From page 71	F 657		

concerns that involve resident care/condition. These updates are to be prompt upon notification and should be reviewed and implemented in the daily clinical meeting and as they occur.

2. The Admission Minimum Data Set (MDS) dated 7/02/24 revealed Resident #23 currently considered by the State Level 2 Pre-Admission Screening and Resident Review (PASRR) to have serious mental illness, intellectual disability, or related condition. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15 to indicate moderate cognitive impairment. MDS assessment documented that Resident #23 had symptoms of feeling down, depressed, or hopeless, without a frequency of mood symptoms indicated. Behavioral symptoms included verbal behaviors, directed at others, and other behavioral symptoms, not directed at others, that interfered with Resident #23's participation in activities or social interactions. MDS indicated that Resident #23 required antipsychotic medication on an as needed only basis. Resident #23 able to transfer and ambulate independently throughout the facility. Diagnoses included Cerebral Vascular Accident (CVA or stroke), non-Alzheimer's dementia, depression, and cirrhosis of the liver.

A Baseline Care Plan with admission the date 6/26/24 revealed Resident #23 at risk for elopement and noted that Resident #23 was a smoker prior to admission but had not been out to smoke. The Baseline Care Plan lacked identification of mood or behavioral symptoms upon admission.

A Hospital History and Physical (H&P) Report, dated 6/01/24, revealed Resident #23 voluntarily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 657		F 657		

Continued From page 72
admitted self to hospital via the Emergency Department (ED), due to reporting suicidal ideation and then admitted as inpatient to the hospital psychiatric unit. Resident #23 had a history of similar inpatient stays with 4 other admissions since 2022. Past Medical History included diagnoses of suicidal ideation and severe, recurrent, Major Depressive Disorder (MDD) without psychotic features. The H&P revealed Resident #23 reported feeling very depressed with plans to hang himself, and went as far as to buy the rope to do so but stated he stopped as he could not find a tree suitable to do so. Resident #23 additionally reported worsening anxiety symptoms such as palpitations, chest heaviness, dyspnea (difficulty breathing), and racing thoughts, contributing to a lack of sleep, as well as visual hallucinations of bugs on the wall.

A Hospital Behavioral Progress Note, dated 6/24/24, revealed Resident #23 continued to endorse feelings of helplessness and remained appropriate for inpatient psychiatric treatment due to suicidal ideation in the setting of medical comorbidities and poor self-care. Disposition likely to be nursing home level of care and planned discharge to facility on 6/25/24.

A Pre-Admission Screening and Resident Review (PASRR), dated 6/24/24, identified Resident #23 as a Level 2 with short stay, time limited, nursing facility approval for 365 days due to current functional needs. Mental health conditions included severe, recurrent MDD without psychotic features, and mood disorder with depressive features due to a medical condition. Past mental health symptoms identified on the PASRR included feelings of hopelessness and worthlessness, thoughts of wanting to end life,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 657		F 657		

Continued From page 73

taking actions to end life, depressed mood, worry, and seeing things that are not real. Noted from a previous PASRR review, dated 6/08/24, Resident #23 had a history of four mental health hospitalizations, in the year 2023, for depressive symptoms and self-harm.
PASRR listed the following services and supports that the admitting nursing facility would be required to provide for Resident #23:
1. Ongoing psychiatric medication management by a Psychiatrist or Psychiatric Nurse Practitioner.
2. Individual therapy by a licensed behavioral health professional.
3. Behavioral health crisis intervention and safety plan.
4. Rehabilitative services.
5. Community placement supports.

The Care Plan, revised on 7/11/24, lacked identification of mood symptoms. Care Plan lacked intervention for monitoring and reporting suicidal ideation or expressions of self harm, and lacked Resident #23 behavioral health crisis interventions and safety plan.

On 8/28/24 at 8:04 AM, current interim Director of Nursing (DON) informed that she had been in position at facility for a short time, therefore did not have sufficient knowledge on Resident #23's mental health conditions but did reveal the expectation that any history of suicidal ideation or expressions of self harm be documented in a resident's plan of care as well as interventions to ensure a residents safety. The DON also revealed the expectation that any PASRR level 2 supports and services a resident required be included in the plan of care and facility implementation of such services as a team effort to the best of facility's ability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ___ B. WING ___	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 657	Continued From page 74	F 657		

3. The Minimum Data Set (MDS) assessment dated 6/05/24 for Resident #2 revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. Diagnoses included: complete traumatic amputation of leg lower extremity, non-Alzheimer's dementia, depression, Diabetes Mellitus, Peripheral Vascular Disease (PVD), and pruritis (itchy skin). MDS indicated Resident #2 had one venous/arterial ulcer present as well as skin tear(s). Resident #2 required antipsychotic medication on a daily basis.

The Care Plan, revised 7/26/24, lacked focus area for impaired cognition, behavioral symptoms, depression diagnosis, or use of psychotropic medication. The Care Plan additionally lacked indication for behavior monitoring or additional interventions for preventing self harm of skin, other than abdominal binder.

The Medication Administration Record (MAR), dated August 2024, revealed order for antipsychotic medication Quetiapine (Seroquel) 50 milligrams (mg) to be given three times a day for agitation, aggression, and exit seeking, started on 6/23/24 and changed to 75mg to be given daily at bedtime for dementia diagnosis on 8/06/24.

Review of Nursing Progress Notes, revealed the following entries:
1. On 5/29/24 at 6:00 PM, Nursing required to change abdominal dressing 4 times since admission due to Resident #2 constant digging at open wounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 657	Continued From page 75 2. On 6/01/24 at 1:09 PM, Resident #2 picked at skin, twisted and ate hair. Nursing indicated behaviors greatly decreased after dosage of antipsychotic medication. 3. On 6/05/24 at 11:28 AM, Resident #2 picked scabs on legs until bleeding, nursing documented application of wound dressings, covered with tubigrips and application of gloves on Resident #2 to lessen picking skin and hair. 4. On 6/15/24 at 02:44 AM, Resident #2 observed scratching deeply at abdominal wound, causing it bleed and then trying to suck fingers. Nursing documented skin surrounding wounds appeared more irritated and indicated wounds would be assessed the following day. 5. On 6/24/24 at 3:28 PM, A referral sent to Televised Psychiatric (tele-psych) Provider. 6. On 7/05/24 at 9:05 AM, Resident #2 picked open wounds on abdomen. 7. On 8/03/24 at 6:45 AM, Resident #2 observed sitting on edge of bed, picking at wounds and putting the debris in her mouth. Nursing also documented that during the night shift Resident #2 pulled her toenail off and found sucking on it. Nurse noted that Resident #2 had been educated daily not to pick at wounds. 8. On 8/06/24 at 2:40 PM, order received to change antipsychotic medication dosage from 50mg three times a day to 75mg at bedtime. 9. On 8/20/24 at 1:58 PM, Resident #2 seen by Psychiatry. On 8/28/24 at 8:04 AM, current interim Director of Nursing (DON), unsure if Resident #2 had current treatment orders for open wounds but is aware that Resident #2 had abdominal wound. DON revealed expectation that picking and self harm behaviors would be care planned as well as interventions to prevent behavior. DON unaware	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 657 Continued From page 76 (F 657)

if Resident #2 had current Psychiatric services, but stated she would need to have this in place.

F 658 SS=D (F 658)

Services Provided Meet Professional Standards
CFR(s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to follow physician's orders when Bilevel Positive Airway Pressure (BiPAP) machine had not been obtained for several weeks to administer as ordered, doses of antibiotics were missed for wound infection, and failed to provide appropriate wound care for 1 of 4 residents (Resident #2), reviewed for professional nursing standards. The facility reported a census of 31 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 6/05/24 for Resident #2 revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. Diagnoses included: complete traumatic amputation of leg lower extremity, non-Alzheimer's dementia, Cerebral Vascular Accident (CVA or stroke), Diabetes Mellitus, Peripheral Vascular Disease (PVD), obesity, and pruritis (itchy skin). MDS indicated Resident #2 had one venous/arterial ulcer present as well as skin tear(s).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 658	Continued From page 77	F 658		

Following physician's order for BiPAP:

The Baseline Care Plan, dated for admission on 5/29/24, revealed Resident #2 required the use of BiPAP treatment.

The Care Plan, revised 7/26/24, lacked a respiratory focus area or interventions related to BiPAP order.

Review of Medication Administration Records (MAR) between 5/29/24 and 8/27/24 revealed an order for administration of BiPAP at night and during day with naps, set at levels 15/5, started on 5/31/24 and discontinued on 8/05/24. The records revealed a number "5" for hold, or "9" for other/see note, on a majority of dates in which BiPAP was ordered as well as many empty or blank spaces for BiPAP administration.

Review of Resident #2 Nursing Progress Notes revealed the following entries:
1. On 5/30/24 at 10:09 PM, Nursing indicated that Resident #2 did not have BiPAP machine at this time and a call had been placed to previous facility to inquire.
2. On 6/01/24 at 2:50 AM, documentation revealed BiPAP not available until delivery the following Monday.
3. On 6/15/24 at 7:56 PM, Nursing noted BiPAP not here and planned to reach out to device supplier.
4. On 6/19/24 at 10:54 AM, call to device supplier in request for BiPAP, nurse indicated they could call again at end of shift.
5. On 7/03/24 at 10:40 AM, nursing indicated information still needed to obtain BiPAP and noted family concern that Resident #2 had developed seizure activity without BiPAP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 658	Continued From page 78	F 658		

6. On 7/07/24 at 1:54 AM, documentation that BiPAP not available since Resident #2 admission.
7. Nursing Progress Notes lacked documentation for physician order to discontinue BiPAP order.

On 8/25/24 at 2:50 PM, Staff Q, Licensed Practical Nurse (LPN) reported that Resident #2 should have a BiPAP but has been without since her admission.

On 8/27/24 at 12:19 PM, Staff E, former Director of Nursing (DON) revealed that Resident #2 had not been admitted with BiPAP machine and attempts had been made to call around and get her one but would require a Neurology appointment or sleep study to obtain. Staff E informed that Resident #2's family would have probably wanted to take her to a Neurology appointment or sleep study.

Following physician's order for antibiotic:

The Care Plan, revised 7/26/24, revealed a focused area for open wounds on abdomen and leg. Care Plan informed that Resident #2 required course of antibiotics started on 7/12/24 due to picking at wounds and causing skin damage. Care Plan also revealed that on 8/08/24, Resident #2 picked off her toenail and created a wound. Interventions instructed staff to use an abdominal binder and dressings to help prevent Resident #2's picking and follow wound care instructions.

In a Discharge Summary from previous facility, dated 5/29/24, Resident #2 had additional diagnoses that included Obsessive Compulsive Disorder and the Multi-Drug Resistant Organism (MDRO): Carbapenem-Resistant Acinetobacter Baumannii (CRAB) . Infection Transfer form

F 658 Continued From page 79 F 658

indicated Resident #2 would require Enhanced Barrier Precautions due to MDRO and open wounds.

Review of Resident #2's facility listed diagnoses, dated 8/28/24, lacked identification of Obsessive Compulsive Disorder or CRAB.

Nursing Progress Note revealed on 6/15/24 at 02:44 AM, Resident #2 observed scratching deeply at abdominal wound, causing it bleed and then trying to suck fingers. Nursing documented skin surrounding wounds appeared more irritated and indicated wounds would be assessed the following day.

The Medication Administration Record (MAR), dated July 2024, revealed an order for the antibiotic Keflex 500 milligrams (mg) to be given 4 times a day for 7 days related to wound infection with start date of 7/12/24 and end date 7/22/24. Review of record revealed 3 of the 7 days, or 10 of the 28 doses, ordered for antibiotic to be given had been left blank.

On 8/19/24 at 2:40 PM, Staff U, Licensed Practical Nurse (LPN), exposed Resident #2's lower abdomen and performed wound care and dressing change to Resident #2's abdominal wound in common area with 2 resident present in area. Wound care supplies set on the couch next to resident, no clean field maintained during wound care. Nurse did not use enhanced barrier precautions for chronic open wound.

On 8/27/24 at 12:19 PM, Staff E, former DON, revealed that Resident #2 had been on antibiotic for infected abdominal wound that appeared to have redness surrounding wound and tan colored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 658 Continued From page 80 F 658

drainage. Staff E unaware of any issues obtaining or administering antibiotic as ordered.

On 8/28/24 at 8:04 AM, current interim Director of Nursing (DON), unsure if Resident #2 had current treatment orders for open wounds but is aware that Resident #2 had abdominal wound. DON revealed a blank spot on MAR would likely indicate medication not given.

The facility policy, titled Medication Administration Guidelines, dated October 2023, revealed the expectation of staff to document administration of medication in the MAR and will contact physician or pharmacy of any concerns regarding the medication. The policy additionally instructed staff to review the MAR after each medication administration is completed to ensure documentation is complete and supports services provided, for identification of omission or inconsistencies within MAR documentation, staff are to report findings to nursing management at the time of discovery and notify physician and responsible party of disruption of care as clinically indicated.

F 660 SS=D Discharge Planning Process F 660
CFR(s): 483.21(c)(1)(i)-(ix)

§483.21(c)(1) Discharge Planning Process
The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 660	Continued From page 81 (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another	F 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 660	Continued From page 82 SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to complete discharge planning for 2 out of 2 residents reviewed (Resident #77, #78). The facility reported a census of 31 residents. Findings include: 1. The Electronic Health Record for Resident #77 dated 8/20/24 listed diagnoses of altered mental status, anemia, and heart disease. The Minimum Data discharge tracking for Resident #77 dated 8/26/24 showed discharge	F 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 660	Continued From page 83 return not anticipated. The Care Plan dated 8/14/24, failed to address discharge planning. The Progress Note for Resident #77 dated from 8/20/24 to 8/27/24 failed to show the location she discharged to and failed to include discharge planning. 2. The Minimum Data Tracking for Resident #78 dated 8/26/24 reflected discharge return not anticipated. The Hospital Encounter Note for Resident #78 dated 8/7/24 included diagnosis of infected pancreatic pseudocyst and tube feeding. The Progress Note for Resident #78 dated 8/25/24 lacked documentation of discharge planning or location she discharged to. On 8/28/24 at 9:27 AM the Director of Nursing (DON) reported the facility expected the discharge planning to include communication to the facility the residents are going to, set up transportation, work with the resident and family. The facility provided a policy titled Documentation Standard dated 7/1/2024 included in miscellaneous Discharge plan and discharge plan review.	F 660		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165260	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 678	Continued From page 84	F 678		

such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to ensure resident Cardiopulmonary Resuscitation or Do Not Resuscitate (DNR) code status was accurately, consistently, and timely communicated to be accessible to staff in case of emergency for three of three resident reviewed for code status and/or advanced directives (Resident #24, Resident #77, Resident #177). The facility reported a census of 31 residents.

Findings include:

1. Review of the Minimum Data Set (MDS) assessment dated 7/18/24 for Resident #24 revealed the resident scored 2 out of 15 on a Brief Interview for Mental Status (BIMS) exam.

Review of the clinical record for Resident #24 revealed the resident admitted to the facility on 7/8/24.

The Physician Order for Resident #24 revised 7/8/24 (date of admission) revealed, Pt (patient) is a full code.

Review of Resident #24's Iowa Physician Orders for Scope of Treatment (IPOST) form dated 7/8/24 (date of admission) selected the option for DNR, comfort measures only, and no artificial nutrition by tube.

On 8/19/24 at 2: 55 PM when queried about the resident's code status, Staff A, Registered Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 678		F 678		

Continued From page 85

(RN) said the resident was a full code, per the chart order for full code.

When shown the resident's IPOST in the electronic health record with the Director of Nursing (DON) present as well as Staff A, the following was explained: The facility would call the family and get it straightened out as was not straightened out when the resident got to the facility.

Review of the resident's Physician Order dated 8/20/24 revealed, DNR and Allow Natural Death.

2. Resident #77, per the clinical record, admitted to the facility on 8/7/24. The Medical Diagnoses section of the Electronic Health Record (EHR) included: inoperative hemorrhage and hematoma of the digestive system organ or structure complicating a digestive system procedure; anemia, and hemoperitoneum (presence of blood in the peritoneal cavity.)

The Care Plan, initiated on 8/7/24, included a Focus Area to address Resident expressed desire for Advanced Care Planning intervention(s). The Focus Area included the Intervention, created on 8/7/24, Do Not Attempt Resuscitation (DNR) and Allow Natural Death.

A review of the clinical record revealed a lack of a Physician Order of a DNR order, and I-POST (Iowa Physician Order for Scope of Treatment) to indicate Resident #77 and or representative choice of Code Status.

During an interview on 8/19/24 at 4:48 p.m., The Director of Nursing (DON) stated she would look

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 678	Continued From page 86	F 678		

for a Physician's Order and start working on the I-POST. The DON stated she had only worked in the facility for a week and did not know the policy.

During an interview on 8/19/24 at 4:50 p.m. The Administrator stated she had expected the I-POST to be initiated within 24 hrs.

3. Resident #177, per the clinical record, admitted to the facility on 8/12/24. The EHR included diagnoses of: unspecified dementia, type 2 diabetes mellitus, and congestive heart failure.

The Care Plan, initiated on 8/7/24, lacked a Focus Area and Interventions for Advanced Directives.

A review of the clinical record revealed a Physician Order, dated 8/19/24, for DNR.

A review of the faciliy I-POST book revealed a lack of a signed I-POST to indicate the resident, or their representative Code Status choice.

The Facility Policy titled Advanced Directives, dated 8/2/22, revealed, A POLST or IPOLST (Physician Orders for Life Sustaining Treatment or Iowa Physician Orders for Life Sustaining Treatment) is a form developed as a more specific and detailed DNR (Do Not Resuscitate) . Like a DNR, the form is completed with the resident's doctor and based on end-of-life decisions. Once signed, doctors and other medical professional must honor the instructions on the POLST/IPOLST. The POLST/IPOST contains sections addressing various aspects of end-of-life medical care such as CPR, Medical interventions such as comfort measures only,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 678 Continued From page 87 F 678

limited additional interventions such as IV fluids, cardiac monitoring, transfers to hospital and full treatments such as intubation, advanced airways, antibiotics, mechanical ventilation, feeding tubes, etc.

F 684 Quality of Care F 684
SS=K CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews, observation, and record review, the facility failed to ensure care and ongoing assessment for a resident that was admitted with 2 abdominal drains with hospital discharge orders from the surgeon to be flushed with saline twice a day, dressing change, and monitor the output daily. No orders were in the clinical record for such care. Resident #78 was sent to the Emergency Department 6 days later, after the State agency notified facility staff of the lack of drain care, abdominal pain 9/10 on pain scale and nausea for multiple days.

The facility also failed to conduct or document assessments for Resident#22 who had been sent to the hospital three times in the time period of 7/1/24 to 8/1/24 and diagnosed with a gastrointestinal hemorrhage (GI Bleed).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 684	Continued From page 88	F 684		

The facility also failed to conduct post-fall assessment and intervention measures for Resident #127 who fell and struck their head on the floor on 8/9/24. Resident #127 displayed a change of decreased meal intake with drooling and pocketing of food and change in ability to take oral medications. Resident #127 remained at the facility until transferred to the Hospital on 8/11/24 where they were diagnosed with an intracranial hemorrhage involving the left lateral aspect of the occipital lobe post fall. Resident #127 transferred from the Hospital to another facility where she passed away on 8/15/24 with the cause of death determined to be intracerebral hemorrhage.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 14, 2024 on August 21, 2024 at 1:00 p.m. As of the exit date the immediacy was not removed.

The facility identified a census of 31 residents.

Findings Include:

1. During an observation on 8/19/24 at 3:39 p.m. Resident #78 had a surgical wound to her left side with a wound vac set on a continuous setting and 2 drains from the abdomen to bulbs with a scant amount of drainage on left and small amount on the right.

During an interview on 8/19/24 at 3:39 p.m. Resident #78 stated the wound vac dressing was scheduled to be changed that day and nursing had not completed that treatment. Resident #78 complained of nausea and vomiting and struggled to eat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684	Continued From page 89	F 684		

During an interview on 8/20/24 at 1:13 p.m., Resident #78 stated the dressings for the wound vac and the drains were changed last Friday 8/16/24. Resident #78 stated, "They only empty the drainage about every 2 days and the doctor stated the drains can come out if I have 5cc or less, so how do they know if it's 5cc's or less daily if they don't empty them daily?" Resident #78 stated the nurse told her the dressing for the wound vac cannot be changed until the supplies arrive. Resident #78 stated she had less nausea but the pain around the drain sites had increased.

The Physician's order for Resident #78 revealed:
a. wound vac on upper left flank change 3 times a weekly on Wednesday, Monday, Friday, setting at 125mmHg suction, with foam dressings black and white.
b. Lack of an order for treatment for the abdominal drains (right and left) dressing change nor when to empty.

The Treatment Administration Record for Resident #78 revealed:
a. The wound vac dressing was changed last on 8/16/24.
b. Lack of documentation of drainage from wound vac.
c. Lack of documentation for the right and left drains for a dressing change and measurement of drainage bulbs.

The Hospital Discharge document dated 8/7/24 with instructions for drain care reveal:
a. Flush both drains with 10 ml saline BID, measure drainage.
b. When drainage decreased to 5 ml notify the surgeon office for an appointment for drain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684		F 684		

Continued From page 90
removal.

During an interview on 8/20/24 at 3:40 p.m., The Director of Nursing (DON) stated the dressings are on order and have not arrived. The DON stated she would call the surgeon to follow up since the nurses were not flushing the drains and will assess the resident.

During an interview on 8/20/24 at 4:39 p.m., The DON stated she called and left a message for the surgeon. The DON stated she called the facility provider since her assessment was positive for pain and nausea, reported that the drains have not been flushed since the readmit on 7/14/24 and received an order to send Resident #78 to the local emergency department for an evaluation. "I really want this taken care of quick".

A record review of the nursing assessments revealed a lack of skilled assessments.

A record review of progress notes on 8/14/24 at 2:51 p.m. Resident #78 returned from the hospital, the assessment lacked an assessment of the 2 abdominal drains and the wound to her right side that had a wound vac attached or what the wound vac setting was.

During an interview on 8/22/24 at 12:42 p.m. Staff A, Registered Nurse stated when Resident #78 returned to the center on 8/14/24, the physician orders had not changed from what the surgeon ordered. Staff A stated when the nurse from the hospital called a report, she said to pull the drains, but did not have an order to discontinue the drains so I did not. Staff A stated she called the surgeon's office and a message was left for the surgeon.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 684		F 684		

Continued From page 91

A record review of the Progress Note on 8/22/24 at 8:24 p.m. revealed the physician orders were reviewed and validated with the admission orders from 8/14/24.

2. Review of the Admission Minimum Data Set (MDS) assessment dated 6/18/24 revealed Resident #22 scored 99 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was unable to complete the interview.

The Care Plan dated 6/7/24 revealed, Resident is incontinent of bowel/bladder related (r/t) Dementia.

The Care Plan dated 8/3/24, revised 8/4/24, revealed, [Resident #22] had duodenal ulcers. Interventions per the Care Plan included the following:
a. (Date Initiated 8/1/24, Created 8/4/24): Observe for dark stools and report to nursing staff.
b. (Date Initiated 8/4/24, Revised 8/8/24): 8/8/24 [Resident #22] had 3 hospitalizations for gastric bleeding, duodenal ulcer and obstructions.

Review of the Assessments tab in the resident's electronic health record lacked any assessments between the dates of 7/1/24 and 8/1/24.

The Health Status Note dated 7/23/24 at 12:41 PM revealed, Staff called me to the unit to assess [Resident #22] and explained he had an unsteady gait today and stated he did not feel well and his head hurt. Pt assessed, vitals obtained, Power of Attorney (POA) advised of [Resident #22's] situation and it was requested to send him to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684	Continued From page 92	F 684		

Emergency Room (ER) for evaluation. Provider notified and Emergency Medical Services (EMS) dispatched. Hard copy of demographics was sent with them and ER was called with report. Will update provider and POA of patient's condition. The Progress Note lacked vital signs for the resident.

Review of the Emergency Department (ED) Note Physician dated 7/23/24 at 4:47 PM revealed the following Chief Complaint: Sent in from [Facility Name Redacted] for hypotension, weakness, and headache. Not hypotensive at this time. The History of Present Illness (HPI) section revealed, ...brought in by EMS for headache and low blood pressure readings. Nursing staff reports patient was found to have low blood pressure readings, SBP (systolic blood pressure) 87, at the care facility this morning. He is complained of nonspecific headache. They admit generalized weakness.

The Assessment/Plan section of the ED Note Physician revealed the following:

a. General weakness
b. Anemia
c. Duodenitis
d. Dehydration
e. Bilateral inguinal hernia

Review of Progress Notes lacked resident's diagnosis or time/date of return to the facility from the hospital. Per Hospital Records, Resident #22 discharged from the hospital on 7/23/24.

The Progress Note by the Physician dated 7/24/24 at 11:00 PM for Date of Service 7/25/24 lacked information about the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ________ B. WING ________	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684	Continued From page 93	F 684		

hospitalization.

The Communication with Family Note dated 7/26/24 at 2:22 PM revealed, Called POA (Power of Attorney) I spoke to his social worker she had me send him out since he is not a DNR (Do Not Resuscitate). Admonition is to call Monday to get the DNR process started.

Review of the resident's Progress Notes lacked assessment of the resident, documentation of clinical condition, or the reason the resident was sent out. Progress notes lacked what time the resident left the facility, what information was sent with the resident, and lacked information about notifications made related to hospital transfer.

The Health Status Note dated 7/26/24 at 5:52 PM revealed, Dr. [Name Redacted] called from [Hospital Name] wanting to know res med list. shortly after [name redacted] from [hospital name] called they are sending res to [hospital name] d/t (due to) anemia et (and) a hemoglobin of 6.3. They attempt (attp) to reach POA unsuccessfully this nurse was also unsuccessful.

The Health Status Note dated 7/27/24 at 5:52 PM revealed, received a call from [hospital name redacted] this shift they had some questions about the resident. Asked what they could tell me about his condition et they are hoping to get him into general surgery for a GI (gastrointestinal) bleed. he has had 2 transfusions and (et) when they have a better report they will contact us.

The Health Status Note dated 7/28/24 at 8:47 AM revealed, rec a call from [hospital name redacted] they are needing to do a procedure on res et have tried to reach the POA but the number is for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684	Continued From page 94	F 684		

an office so they haven't been able to reach them. this nurse gave them the number for the "guardian/ [name redacted]" on our profile in hopes someone can be reached.

Review of Hospital Records for Resident #22 revealed the following:

Review of Discharge Documentation from Hospital Records for admission date 7/26/24 and discharge date 7/29/24 revealed reason for hospitalization as weakness. Discharge diagnosis included gastrointestinal (GI) bleed.

Review of Diagnostic Results from a computed tomography (CT) Abdomen and Pelvis W Contrast dated 7/26/24 revealed clinical history of GI bleed. Findings per the Bowel section revealed, Focal inflammatory changes again seen associated with the proximal duodenum small surrounding lymph nodes. Moderate to large amount of stool in the rectum.

The Operative Report dated 7/28/24 at 10:27 AM revealed the following:

a. Indication for Surgery: melena, impacted stool
b. Post-Operative diagnosis: Impacted stool, melena, no palpable mucosal lesions
c. Operation: Removal of impacted stool, rectum, requiring anesthesia

The Operative Report dated 7/28/24 at 10:30AM revealed the following Post-Operative Diagnosis:
a. Esophagogastroduodenoscopy: 2 prominent duodenal ulcers of the proximal aspect of the duodenal bulb, just post pyloric.

b. Flexible sigmoidoscopy: Extensive hard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 684	Continued From page 95	F 684		

melanotic stool. No mucosal lesions. Scope blocked by solid stool at about 25 centimeters (cm) from the anal verge.

The Surgical Progress Note dated 7/28/24 at 10:35 AM revealed, Pt brought to Emergency Room (ER) by [Name Redacted] Emergency Medical Services (EMS) with complaints of (c/o) increase weakness, large dark stool and abdominal (Abd) pain. Pt was given 50mcg (microgram) of Fentanyl (a narcotic pain medication) by [EMS Name Redacted]. The Subjective section of the note revealed the resident had melena per rectum, severity documented as severe, with duration of several days and timing intermittent. The Assessment/Plan noted the resident had a GI (gastrointestinal) bleed, and explained the resident's hemoglobin had been 6.1 (normal: 14-18).

Review of the resident's Progress Notes between 7/28/24 and 7/31/24 lacked when the resident returned to the facility, diagnoses, or additional information as to why the resident had been hospitalized.

Review of Medical Diagnoses for Resident #22 revealed gastrointestinal hemorrhage had been added on 7/29/24.

Review of the Health Status Note dated 8/3/24 at 1:15 PM revealed, called to the unit for [Resident #22] as he had a copious amount of coffee ground emesis. [Resident #22] unable to walk and is doubled over holding his abdomen. POA called and advised to send him to ER, provider notified, regional nurse notified. Report called to ER and hard copy of chart sent with EMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684	Continued From page 96	F 684		

Review of the Internal Medicine Progress Note dated 8/5/24 at 4:30 PM revealed the following Chief Complaint: Pt arrived via EMS from [Facility Name Redacted] Nursing Home with weakness and coffee ground emesis x1. Hx (history) of GI bleed.

The Health Status Note dated 8/8/24 at 12:00 PM revealed, [Resident #22] returned from [Name Redacted] Hospital today. Met him at the door and he seemed to be in a very good mood. He has no c/o pain or discomfort. Nurse called report to facility and stated [Resident #22] had an NG (nasogastric) tube for 24 hours due to a gastric blockage. The decompression from the NG tube was successful so no surgery was performed. [Resident #22] also had 2 copious amounts of stool, no blood present. An antibiotic was ordered for gastritis. Will place the order through our pharmacy and make our provider aware. Diet has been changed to mechanical moist and encourage more liquids.

The Health Status Note dated 8/8/24 at 3:27 PM revealed, [Hospital Name Redacted] stated they were sending an antibiotic in for [Resident #22]. No antibiotic sent in/ordered. Will call our provider.

Review of the resident's Baseline Care Plan dated 8/8/24 revealed the following question and answer: 3. Constipation present? no.

The Health Status Note dated 8/22/24 at 11:30 AM revealed, Resident N/V/D (nausea, vomiting. diarrhea), emesis x2, dark tarry loose stool, history of GI bleed, resident refusing to have vitals taken, Dr. [Name Redacted] notified, send

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684	Continued From page 97	F 684		

to ER for evaluation.

The Health Status Note dated 8/22/24 at 11:51 AM revealed, EMS here to take resident, resident cooperative, reports stomach pain, unable to rate, refused medications this am, refused all cares, list of medications, face sheet, and ipost sent with resident and EMTs (Emergency Medical Technicians).

The Late Entry Health Status Note dated 8/22/24 at 5:07 PM revealed, received call from [Hospital Name Redacted Emergency Room], resident HGB (hemoglobin) 4.8, requiring PRBC (packed red blood cells), then trying to move him to acute hospital, scans not showing acute bleed.

On 8/21/24 at 3:00 PM, Staff I, Certified Nursing Assistant (CNA) explained she was at facility when the resident was sent out for dark vomit. Per Staff I, all the resident's food came back up when came back from the hospital. Staff I explained she believed this was recent, beginning of the month she believed.

On 8/22/24 at 11:37 AM, Staff C, CNA explained one weekend, later clarified as dayshift, she had been in the unit (dementia unit), and Resident #22 puking up blood. Per Staff C, a different resident fell in the front of the facility, and her and [Nurse name redacted] were both running back and forth. Staff C explained the following about [Resident #22's] appearance: Per Staff C the resident looked pale-ish, didn't want to do anything or even walk which was not normal for the resident. The resident started puking up blood, and when calling 911 a different resident fell up front, so two ambulances were called at the same time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ___ B. WING ___	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684	Continued From page 98	F 684		

On 8/22/24 at 12:42 PM during an interview with Staff E, former Director of Nursing (DON), Staff E explained it was reported to the staff nurse the resident did not want to eat breakfast. Staff E explained she went back and said, are you doing ok? Per Staff E, the resident said yeah, go, go, go which told Staff E the resident was going to "ramp up". Staff E explained Staff D, Activity Director happened to pass by the resident's room, the resident did not get up, and Staff D went to talk to him. Per Staff E, Staff D noticed a depend in the garbage with copious amount of black stool. Staff E explained Staff D snapped a picture of it on phone and came and showed Staff E and asked if normal.

Per Staff E, Staff E asked, where is that depend? Staff E explained when she went back the depend was gone, and Staff E explained she did not feel real good about it. Staff E explained the resident sitting on the edge of bed doubled over and holding abdomen. Staff E explained she asked the resident if the resident's tummy hurt, response provided was yes, and resident asked if wanted to be sent out. The response was yes, the POA notified, and was asked if wanted to send the resident out.

Per Staff E, the hospital said the resident had fecal impaction liver to rectum, the resident had an NG tube in, and was given pain meds and fluids. Staff E explained the resident had EGD (esophagogastroduodenoscopy) and had active duodenal ulcers. Staff E explained a colonoscopy was tried, the resident was not compliant with the prep, and could only go in a few inches and they met the fecal impaction. Per Staff E, she was called the next day, the resident ended up being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684	Continued From page 99	F 684		

given MiraLAX (laxative medication) and they said he had a massive amount of fecal material come out within just a few hours. Staff E explained then the resident was hungry and, in less pain, and they ended up clearing the fecal impaction with follow up x-rays.

Per Staff E, the resident came back (to facility), and then Staff E explained she needed to send the resident out again because another large amount of black stool, and resident doubled over holding stomach. Staff E explained they asked the resident if their stomach hurt, and response yes. Staff E asked the resident if sure he did not want to go to (out), POA was notified, and resident said just wait, just wait. Staff E explained the resident was still at the edge of his bed, the POA said to send the resident again.

When queried about paperwork that would be completed if someone out, Staff E explained would send hard chart, and if look by nurses' station, everyone's code status, all meds, generally Kardex info about them, and would make a copy to give to EMS. When queried about assessment tab (in electronic health record), Staff E explained she was just told about the transfer forms before [out of facility].

On 8/25/24 at 2:25 PM, Staff Q, Licensed Practical Nurse (LPN) queried if she had been at facility when Resident #22 had GI issues. Per Staff Q, she was present one of the days the resident was sent out, and explained a lot was handled by [Former DON, Staff E]. Per Staff Q, a lot of the times the CNAs had a place where they could chart pain, behaviors, and they would chart it and wouldn't say it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 684	Continued From page 100	F 684		

On 8/28/24 at 8:42 AM, the Interim Director of Nursing (DON) present at time of survey queried about a plan if a resident had impaction/GI bleed/ulcers. Per the DON, would monitor for stools if black, red, or anywhere in between, and then constipation, diarrhea, any change with any type of need to monitor closely, vomit, and coffee ground emesis. Per the DON, stools would be monitored as close as can mainly looking for black and red. When queried as to where she would look for information about resident clinical symptoms, the DON responded the [initials redacted] assessment or prog notes. When queried if nurses had approached her with questions about assessments/what they were to be doing, the DON acknowledged they had not done so.

The policy titled Change of Condition/Incident Reporting dated 8/2023 revealed when a resident exhibits a change of condition, actions will be taken to coordinate care to meet resident needs.

3. Resident #127 admitted to the facility on 8/09/24 from the Hospital. No Minimum Data Set (MDS) entry assessment or Medicare 5 day assessment completed or submitted, assessments remained in progress status. No MDS discharge assessment initiated for discharge to the hospital on 8/11/24.

The facility's Electronic Health Records (EHR) was absent for a baseline Care Plan assessment, required to be completed within 48 hours of admission.

Resident #127's medical record lacked a completed plan of care to address care needs, preferences, high-risk medications, or safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 684		F 684		

Continued From page 101
risks.

The Clinical Admission Assessment, dated 8/09/24, revealed Resident #127 had moderate cognitive impairment with symptoms of agitation and anxiety and wandered at night. The assessment revealed that Resident #127 had no nutritional concerns upon admission and had one area of skin impairment with redness noted to the coccyx. No safety care needs or functional abilities identified in the Admission Assessment.

The Hospital History and Physical (H&P), dated 8/01/24, revealed Resident #127 had presented to the Hospital with altered mental status. The H&P informed that Resident #127's Computed Tomography (CT) scan and urinalysis (UA) had both shown negative results.

A Head CT scan, without intravenous contrast, performed at the Hospital and signed by Provider on 8/01/24, revealed findings of no acute intracranial abnormality.

A review of the facility's Nursing Progress Notes, revealed the following entries:
1. On 8/09/24 at 12:41 PM, Facility Nurse received report from Hospital Nurse. Resident #127 arrived to facility via private car. Nursing noted all orders and assessments completed.
2. On 8/09/24 at 2:47 PM, Resident #127 stood and fell to the floor in common area. Two Certified Nursing Assistant (CNA) staff observed the fall. Nursing noted a small skin tear on back of left hand but unable to determine if fall caused the skin tear. Two staff assisted Resident #127 back into wheelchair and Nursing documented neurological checks to be performed.
3. On 8/10/24 at 12:37 AM, an as needed dose of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 684 Continued From page 102 F 684

the antipsychotic medication Olanzapine 5 milligrams (mg) given due to Resident #127 behavioral symptoms of screaming "help me, help me", "please, please", agitation, and physical aggression towards staff. Nursing noted medication had been ineffective in symptom management.
4. On 8/10/24 at 4:55 PM, Resident #127 continued to yell when awake. Nursing noted resident refused the midday meal but ate nearly all of the morning meal, and took crushed medications without issue.
5. On 8/10/24 at 11:00 PM, an entry from the Nurse Practitioner (NP) indicated Resident #127 was not swallowing, even pureed foods, drooling, and pocketing food. NP noted that a tele-health visit offered, but informed that due to the inability of Resident #127 to take oral medications and a decrease in oral intake, recommendation made to send Resident #127 out to Hospital for failure to thrive and a psychiatric evaluation related to aggression.
6. On 8/11/24 at 1:45 PM, Nurse called 911 to send Resident #127 to the Emergency Room (ER) and called the Hospital to give report.
7. On 8/11/24 at 1:50 PM, Resident #127 transferred from facility via ambulance to Hospital ER for evaluation and treatment of psychiatric issues and for failure to thrive.

The facility Incident Report, dated 8/09/24 at 2:20 PM, revealed Resident #127 had been in the common area self-propelling in a wheelchair when she stood up and fell to the floor, resident assisted with 2 staff back to chair and neurological checks initiated. The Incident report informed that predisposing physiological factors included confusion, recent change in cognition, gait imbalance and a situational factor of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 684	Continued From page 103	F 684		

Resident #127 attempted to ambulate without assistance. The Incident Report revealed that a statement had been provided by Staff P, CNA, and notification of incident provided to the Physician, Responsible Party, Director of Nursing, and Facility Administrator.

Facility was unable to produce neurological checks completed on Resident #127 post fall occurring on 8/09/24.

Review of Resident #127's Electronic Health Records (EHR) lacked post fall, 8/09/24, documentation or follow up assessments completed.

The facility self-reported the incident, marked as "other" incident type to the State Office on 8/12/24. In request of the investigation into self-reported incident, the facility provided a file that contained Resident #127 hospital notes, timeline dated between 8/01/24 through 8/09/24, prior to admission to the facility.

On 8/21/24 at 1:46 PM, Staff P, CNA, informed that on 8/09/24 around 2:00 PM, Resident #127 displayed agitated and restless behaviors, when the resident was leaning forward and backward in her wheelchair while in the common area. Staff P revealed she witnessed Resident #127 stood up from the wheelchair and fell forward, Staff P was unable to reach her in time. Staff P stated Resident #127 hit the upper left side of her forehead on the floor when she fell, and obtained a scratch on her hand.

On 8/22/24 at 12:04 PM, Staff E, former Director of Nursing (DON), reported observation of Resident #127 on the floor in the common area,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 684	Continued From page 104	F 684		

down on her left side, following a fall from the wheelchair on 8/09/24. Staff E said she had been informed that Resident #127 stood up without assistance, tipped forward, and landed on the ground. Staff E stated Resident #127 had agitated behaviors at the time of the fall and revealed that due to continued behaviors and disturbance of other residents, it was decided for Resident #127 to move to a room in the unoccupied West hallway. Staff E reported that no one said anything about Resident #127 pocketing food until 2 days later when the charge nurse sent the resident out to the hospital.

An Emergency Department note, dated 8/11/24, revealed Resident #127 arrived via ambulance from the facility with the chief complaint of failure to thrive and psychiatric evaluation related to combativeness, not eating, and insomnia. Physical examination revealed mild swelling and bruise noted to the right occipital (back of head). Hospital diagnosed Resident #127 with intracranial hemorrhage and altered mental status with plans for Resident #127 to transfer to a different facility and receive comfort cares.

A Hospital note, dated 8/11/24, revealed a Head CT scan performed due to fall and altered mental status, findings included a 2.5 centimeter (cm) focus of parenchymal hemorrhage involving the left occipital lobe.

A Death Certificate for Resident #127, listed the date of death on 8/15/24 at 7:40 AM. Immediate cause of death determined to be intracerebral hemorrhage.

On 8/28/24 at 8:04 AM, the current interim Director of Nursing (DON) informed that fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 684 Continued From page 105 — F 684

protocol included immediate nurse assessment of residents and completion of neurological checks if a resident hit their head, had an unwitnessed fall, or if resident was unable to verbalize if head had hit during fall. Additionally, DON expected nurses to complete post fall assessment every shift for 3 days.

The facility policy titled, Accidents and Incidents Investigating and Reporting, Event Management, revised January 2021, revealed an expectation for documentation of all findings and observations to be completed every shift for 72 hours following an incident with head injury. Documentation to include neurological assessment every 15 minutes for 2 hours, then every 30 minutes for 2 hours, then every shift for 72 hours and instructed staff to continue neurological checks and vital signs as indicated until normal. Post head injury documentation to also include resident's pupil response, motor function, vital signs, changes in alertness, and pain. Additional instruction to seek appropriate intervention if assessment shows abnormal findings, which informed staff to document what was done and the resident's response.

F 689 SS=E — F 689

Free of Accident Hazards/Supervision/Devices
CFR(s): 483.25(d)(1)(2)

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

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 106	F 689		

by:
Based on observation, interview, clinical record review, and facility policy review, the facility failed to ensure safe resident transfers, wheelchair transport, and monitoring for falls and assessments for 3 of 12 residents (Resident #2, #127, and #77). The facility also failed to provide a safe environment ensuring supervision for 1 of 12 residents reviewed for accidents when Resident #17 moved into a room with another resident, despite a history of resident to resident altercations between the two residents. The facility reported a census of 31 residents.

Findings include:

1. Resident #127 admitted to the facility on 8/09/24 from the hospital. No Minimum Data Set (MDS) entry assessment or Medicare 5 day assessment completed or submitted, assessments remained in progress status.

The facility's Electronic Health Records (EHR) lacked a baseline Care Plan,

Resident #127's Care Plan found to be blank. The Care Plan lacked any information on Resident #127's care needs, preferences, high-risk medications, or safety risks.

The Clinical Admission Assessment, dated 8/09/24, revealed Resident #127 had moderate cognitive impairment with symptoms of agitation and anxiety and wandered at night. The Assessment revealed that Resident #127 had no nutritional concerns upon admission and had one area of skin impairment with redness noted to coccyx. No safety care needs or functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689		F 689		

Continued From page 107
abilities identified in the Admission Assessment.

The Hospital History and Physical (H&P), dated 8/01/24, revealed Resident #127 had presented to the hospital with altered mental status. The H&P informed that Resident #127's Computed Tomography (CT) scan and urinalysis (UA) had both shown negative results.

A head CT scan, without intravenous contrast, performed at the hospital and signed by the provider on 8/01/24, revealed findings of no acute intracranial abnormality.

A hospital note, dated 8/07/24, revealed the head CT noted no acute process; Plavix 75mg and aspirin 81mg to be held due to family preference and low platelet count.

A review of the facility's Nursing Progress Notes, revealed the following entries:
1. On 8/09/24 at 2:47 PM, Resident #127 observed self-propelling wheelchair in common area when she stood up and fell to the floor. Two Certified Nursing Assistant (CNA) staff observed the fall. Nursing noted a small skin tear on back of left hand but unable to determine if fall caused the skin tear. Two staff assisted Resident #127 back into wheelchair and Nursing documented neurological checks to be performed.
2. On 8/10/24 at 12:37 AM, an as needed dose of the antipsychotic medication lanai 5 milligrams (mg) given due to Resident #127 behavioral symptoms of screaming "help me, help me", "please, please", agitation, and physical aggression towards staff. Nursing noted medication had been ineffective in symptom management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 108	F 689		

3. On 8/10/24 at 4:55 PM, Resident #127 continued to yell when awake. Nursing noted resident refused the midday meal but ate nearly all of morning meal, and took crushed medications without issue.
4. On 8/10/24 at 11:00 PM, an entry from Nurse Practitioner (NP) indicated Resident #127 was not swallowing, even pureed foods, drooling, and pocketing food. NP noted that a tele-health visit offered, but informed that due to the inability of Resident #127 to take oral medications and a decrease in oral intake, recommendation made to send Resident #127 out to Hospital for failure to thrive and a psychiatric evaluation related to aggression.
5. On 8/11/24 at 1:45 PM, Nurse called 911 to send Resident #127 to the Emergency Room (ER) and called the Hospital to give report.
6. On 8/11/24 at 1:50 PM, Resident #127 transferred from facility via ambulance to Hospital ER for evaluation and treatment of psychiatric issues and for failure to thrive.

The facility Incident Report, dated 8/09/24 at 2:20 PM, revealed Resident #127 had been in common area self-propelling in wheelchair when she stood up and fell to the floor, resident assisted with 2 staff back to chair and neurological checks initiated. The Incident report informed that predisposing physiological factors included confusion, recent change in cognition, gait imbalance and a situational factor of Resident #127 attempt to ambulate without assistance. The Incident Report revealed that a statement had been provided by Staff P, CNA, and notification of incident provided to the Physician, Responsible Party, Director of Nursing, and Facility Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ___ B. WING ___	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 109	F 689		

Facility unable to produce neurological checks completed on Resident #127 post fall occurring on 8/09/24.

Review of Resident #127's Electronic Health Records (EHR) lacked post fall, 8/09/24, documentation or follow up assessments completed.

The facility self-reported incident as "other" incident type to the State Office on 8/12/24. In request of the investigation into self-reported incident, the facility provided a file that contained Resident #127 hospital notes, timeline dated between 8/01/24 through 8/09/24, prior to admission to the facility.

On 8/21/24 at 1:46 PM, Staff P, CNA, informed that on 8/09/24 around 2:00 PM, Resident #127 displayed agitated and restless behaviors, when resident was leaning forwards and backwards in her wheelchair while in the common area. Staff P revealed she witnessed Resident #127 stand up from wheelchair and fall forward, Staff P unable to reach her in time. Staff P stated Resident #127 hit the upper left side of her forehead on the floor when she fell, and obtained a scratch on her hand.

On 8/22/24 at 12:04 PM, Staff E, former Director of Nursing (DON), reported observation of Resident #127 on the floor in common area, down on her left side, following fall from wheelchair on 8/09/24. Staff E said she had been informed that Resident #127 stood up without assistance, tipped forward, and landed on the ground. Staff E stated Resident #127 had agitated behaviors at the time of fall and revealed that due to continued behaviors and disturbance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 110	F 689		

of other residents, it was decided for Resident #127 to move to a room in the unoccupied West hallway. Staff E reported that no one said anything about Resident #127 pocketing food until 2 days later when the charge nurse sent resident out to the hospital.

An Emergency Department note, dated 8/11/24, revealed Resident #127 arrived via ambulance from the facility with chief complaint of failure to thrive and psychiatric evaluation related to combativeness, not eating, and insomnia. Physical examination revealed mild swelling and bruise noted to right occipital (back of head). Hospital diagnosed Resident #127 with intracranial hemorrhage and altered mental status with plans for Resident #127 to transfer to a different facility and receive comfort cares.

A Hospital note, dated 8/11/24, revealed a Head CT scan performed due to fall and altered mental status, findings included a 2.5 centimeter (cm) focus of parenchymal hemorrhage involving the left occipital lobe.

A Death Certificate for Resident #127, listed the date of death on 8/15/24 at 7:40 AM. Immediate cause of death determined to be intracerebral hemorrhage.

On 8/28/24 at 8:04 AM, the current interim Director of Nursing (DON), revealed that fall protocol included immediate nurse assessment of resident and completion of neurological checks if a resident hit head, had unwitnessed fall, or if resident was unable to verbalize if head had hit during fall. Additionally, DON expected nurses to complete post fall assessment every shift for 3 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 111	F 689		

2. The Minimum Data Set (MDS) assessment, dated 6/05/24, revealed Resident #2 Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating moderately impaired cognition. Resident #2 had impairment to both lower extremities, utilized a limb prosthesis and a manual wheelchair for mobility. Resident #2 able to wheel herself with set up assistance 50 to 150 feet. Diagnoses included: non-Alzheimer's dementia, complete traumatic amputation of left lower extremity, cerebral vascular accident (CVA or stroke), peripheral vascular disease (PVD), and diabetes mellitus.

The Care Plan, dated 6/19/24, revealed Resident #2 had a prosthetic leg and is high risk for falls related to confusion, gait and balance problems with the goal that resident will not sustain serious injury through the review date. Interventions instructed staff to follow facility fall protocol and educate resident, family, and caregivers about safety reminders and what to do if a fall occurs.

On 8/19/24 at 12:23 PM, Staff D, Activity Director, pushed Resident #2 in wheelchair from the dining room to living room without foot pedals in place on wheelchair, resident held right leg and left prosthetic leg up during transport.

On 8/19/24 at 2:48 PM, Staff Z, Certified Nursing Assistant (CNA) and Certified Occupational Therapy Assistant (COTA) assisted Resident #2 up from couch in common area and stand, pivot transferred her using gait belt into wheelchair. COTA then transported Resident #2 via wheelchair, without foot pedals in place, to resident's room. Resident #2 held right leg and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 689	Continued From page 112	F 689		

left prosthetic leg up during transport through the hallway.

On 8/19/24 at 2:59 PM, COTA transported Resident #2 in wheelchair back from her room to the common area, no foot pedals in place, resident again held her right leg and prosthetic left leg up during transport through the hallway.

On 8/20/24 at 9:07 AM, CNA pushed Resident #2 in wheelchair from dining room to activity room without foot pedals in place.

On 8/20/24 at 9:25 AM, CNA pulled Resident #2's wheelchair behind CNA, holding onto the front left hand rest, and transported Resident #2 from the dining room to resident's room without foot pedals in place. Resident #2 held her right leg and left prosthetic leg up off the floor during transport.

On 8/21/24 at 2:12 PM, Staff G, CNA, stated no residents should be pushed in wheelchair without pedals in place and revealed that Resident #2's foot pedals would typically be kept in the bag hung on back of wheelchair, or in her closet.

On 8/28/24 at 8:04 AM, current interim Director of Nursing (DON) revealed the expectation that foot pedals are in place any time staff push a resident in a wheelchair and informed she would have concerns for safety if foot pedals were omitted during a resident transport.

3. The Minimum Data Set (MDS), dated 6/01/24, revealed Resident #17 had severely impaired cognition with delusions, wandering, and verbal behaviors. Resident #17 able to transfer and ambulate throughout the facility independently. Diagnoses included included moderate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 689		F 689		

Continued From page 113

non-Alzheimer's dementia with behavioral disturbance and insomnia.

The Care Plan, revised 3/19/24, revealed Resident #17 had impaired cognitive function and triggered delirium related to dementia. Intervention instructed staff to redirect and provide gentle reality orientation as required.

Review of Nursing Progress Notes revealed an entry on 8/19/24 at 12:01 PM, Resident #17 reported her room mate hit her in the arm, denied pain, and refused for nurse to assess arm.

On 8/19/24 at 12:47 PM, Staff N, former Administrator, informed that report received from Resident #17 that she had been hit by Resident #20, the morning of 8/19/24. Staff N notified that she would self report the incident to State Office.

A Facility-Reported Incident submitted to State Office on 8/19/24 at 1: 04 PM, for allegation of abuse between Resident #20 and Resident #17. Report revealed Resident #17 alleged that Resident #20 had hit her shoulder, no redness or evidence of incident and Resident #17 denied incident took place during follow up assessment.

On 8/21/24 at 2:12 PM, Staff G, Certified Nursing Assistant (CNA) stated that Resident #20 had a lot of hallucinations and that Resident #17 and Resident #20 had gotten very aggressive with each other at times.

On 8/27/24 at 7:36 AM, Resident #17 previously resided next door to Resident #20. Resident #17 moved to share a room with Resident #20.

The MDS list revealed an assessment in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 114	F 689		

progress, dated 8/27/24, for Resident #17 that indicated discharge with return not anticipated.

On 8/28/24 at 8:04 AM, current interim Director of Nursing (DON), revealed the expectation that residents whom had former altercations would not share a room together to prevent future altercations or incidents.

The facility policy titled, Accidents and Incidents Investigating and Reporting, Event Management, revised January 2021, revealed an expectation that any accident or incident must be reported to the supervisor as soon as it is discovered or when information is learned about incident. The policy additionally revealed the expectation that documentation of all findings and observations to be completed every shift for 72 hours following an incident with head injury. Documentation to include neurological assessment every 15 minutes for 2 hours, then every 30 minutes for 2 hours, then every shift for 72 hours and instructed to continue neurological checks and vital signs as indicated until normal. Post head injury documentation to also include resident's pupil response, motor function, vital signs, changes in alertness, and pain. Additional instruction to seek appropriate intervention if assessment shows abnormal findings, which informed staff to document what was done and the resident's response.

The facility policy titled Freedom of Abuse, Neglect, and Exploitation Policy, revised October 2023, revealed intent of policy is to take all steps reasonable and necessary to protect the residents from harm at all times, including protection from any type of abuse from other residents. The policy instructed staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 115	F 689		

immediately intervene if a resident to resident altercation occurs, and informed that it was imperative to keep residents safe by separation or other interventions while investigation is in progress.

4. The Activity of Daily Living assessment dated 8/7/24 for Resident #77 revealed total dependence on 2 staff for bed mobility, transfers and toileting.

The Care Plan failed to provide direction for staff when transferring and toileting.

During an interview on 8/19/24 at 3:21 p.m., Resident #77 stated the staff dropped her after she was admitted and expressed fear of being dropped again.

Progress notes on 8/8/24 and 8/9/24 for Resident #77 revealed she was lowered to the floor, two separate incidents, due to weakness and a mechanical lift was used to lift her from the floor. There was a lack of nursing follow up notes on both falls and a lack of physician and family notification of falls.

A document dated 8/11/24 signed by Staff K, Certified Nursing Assistant (CNA) wrote on 8/11/24 at 2:44 p.m. that she was instructed by Staff D, Social Services/Activity Director (SS/AD) to assist Resident #77 to the toilet. A report on 8/10/24 instructed Staff K to utilize a mechanical lift for Resident #77 and Staff D stated only 1 person was needed and she could stand, pivot and assist the resident to the toilet. Resident #77 stated she could not stand. Staff D instructed Staff K to grab Resident #77 by the arm, stand her and pivot her to the wheelchair. Staff D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 116	F 689		

wheeled resident to the bathroom, instructed her to stand using the grab bar, and when she could not, Staff D instructed Staff K to grab her arm, put her on the toilet, then return resident to the wheelchair and bedside. Resident was lowered to the floor. Staff D instructed Staff k to help left Resident #77 to the bed.

A review of the progress notes dated 8/11/24 through 8/12/24 revealed a lack of a nursing fall assessment, follow up, physician or family notification of the fall.

During an interview on 8/22/24 at 10:24 a.m. Staff K, CNA stated that when she arrived for the 2p-10 p.m. shift and was confronted by Staff D. Staff K stated Staff D was very aggressive with Resident #77, stating if she wanted to go home, she had to get up and walk. Resident #77 stated she could not stand and walk. Staff K stated Staff D told her to grab Resident #77's arm to sit her up and stand her. Staff K stated Resident #77 could not stand and it was like "dead weight" without a gait belt. Staff K stated she told Staff D that she could not force someone to do something but Staff D stated she was out of patience and spun Resident #77 into the wheelchair, pushed her to the bathroom and forced Resident #77 to the toilet by grabbing her arm to stand her. Staff K stated Resident #77 continued to tell Staff D that she could not stand. Staff K stated after 2 minutes of Resident #77's inability to void, Staff D stated that she had to go home, instructed Staff K to grab her arm, pivoted and sat the resident in the wheelchair and wheeled her to the bedside. Staff K stated Staff D had her back to the bed and took Resident #77 by the arm to stand her and the resident went to the floor with her feet straight out in front of her. Staff K stated her training

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 689	Continued From page 117	F 689		

taught her to get the nurse and a mechanical lift to help the resident back to bed after a fall. Staff K stated that Staff D said "No, grab her arm and lift her". Staff K stated they were able to stand Resident #77, then Staff D spun the resident who fell onto Staff D into the bed. Staff K stated the door opened and the Director of Nursing (DON) stepped into the room, then stepped out then Staff J, CNA entered the room and assisted to get Resident #77 into the bed. Staff K stated she went to the nurses station, reported to the nurse and since the DON and Staff D left the building, Staff K was instructed to report to the Administrator who was in the dementia unit. Staff K stated the Administrator instructed to write a statement and place it on her desk.

During an interview on 8/22/24 at 11:21 a.m. Staff E, former Director of Nursing stated Resident #77 was refusing to get out of bed on the day of admission due to pain and weakness and was a maximum assist of 2 persons with a mechanical lift as she could not bear weight. Staff E stated on 8/11/24 she heard Resident #77 calling out, checked in on her and found Staff D, SS/AD and Staff K, CNA providing incontinent care for Resident #77. Staff E stated she was not aware of Resident #77 being lowered to the floor or she would have made a report on the incident.

During an interview on 8/25/24 at 1:10 p.m. Staff J, CNA stated he was in fear of retaliation if he spoke with a surveyor and the corporation was setting the staff up for failure by not providing enough staff to provide care for multiple weeks. Staff J stated that Resident #77 was a 2 person assist and expressed her fear of being dropped. Staff J stated with the lack of staff, he has had to rely on the nurse to be the second person during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689	Continued From page 118	F 689		

care and when using the mechanical lift.

During an interview on 8/25/24 at 1:37 p.m. Staff Q, Licensed Practical Nurse (LPN) stated on 8/11/24 Staff K, CNA came up to the nurses desk and said "I never want to do that again". Staff Q stated that Staff K explained that Staff D, SS/AD tried to make Resident #77 walk to the bathroom and she needed the mechanical lift up to the wheelchair. Staff Q stated Staff A, RN was present and took staff K to the Dementia unit to report the incident to the Administrator, then returned to the nurse station and wrote out a statement, then placed it on the Administrator's desk. Staff Q stated she checked on Resident #77 but did not complete a fall assessment nor a follow up fall assessment. Staff Q stated if a resident was lowered to the floor, the staff are to notify the nurse on duty.

During an interview on 8/28/24 at 8:40 a.m. Staff D, SS/AD stated she had worked 8/11/24 on the 6a-2p shift. Staff D stated that she needed assistance for Resident #77 who needed the bathroom. Staff D stated that Staff K, CNA assisted Resident #77 up to the wheelchair and to the bathroom. Staff D stated she did have to assist the resident from the toilet to the wheelchair and to the bedside. Staff D stated that Resident #77 was falling and had to be lowered to the floor, down her leg and onto her feet. Staff D said Resident #77 urinated on her leg and "it was not a graceful transfer but it's better than being on the floor". Staff D stated she stood Resident #77 by "scooping her arm" and Staff K placed a gait belt on the resident and had her hands on the gait belt then transferred the resident to the bed. Staff D stated Staff E, DON peeked into the door then Staff J, CNA entered the room to assist. Staff D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 689 Continued From page 119 F 689

stated she left the facility then and did not visualize nursing staff to report the incident to. Staff D stated there are not enough staff to care for the residents and the administrator was having noncertified staff providing care.

A policy titled Accidents and Incidents Investigating & Reporting dated 1/2021 revealed:
a. Disclosure of all accidents or incidents/events involving resident, employees, visitors occurring at the facilities must be investigated and reported to the Administrator.
b. Investigation into the cause of any incident will be tracked in order to improve care and to prevent further occurrences.
c. All staff are to follow the facility policy on communicating proper notifications to residents, representatives, families, medical providers, and regulatory agencies including law enforcement regarding adverse events and incidents.
d. Regardless of how minor an accident or incident may be, it must be reported to the department supervisor as soon as the accident/incident is discovered or when information of such accident/incident is learned.
e. An incident report form must be completed for all reported accident or incidents.
f. An employee witnessing an accident or incident involving a resident, employee or visitor, must report such occurrences to his or her immediate supervisor as soon as possible.
g. The nurse supervisor/charge nurse must be immediately informed of the accidents or incidents so that medical attention can be provided.

F 697 SS=J Pain Management F 697
CFR(s): 483.25(k)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 697		F 697		

Continued From page 120

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident and staff interviews, clinical record review and policy review, the facility failed to provide pain intervention for Resident #77 who admitted on 8/7/24 with an order for as needed narcotic pain medication and complained of pain 10/10 in both knees upon admission. Resident #77 did not receive the narcotic as it was unavailable, the provider was notified on 8/10/24 and Tylenol was first administered on 8/11/24 at 9:54 AM. Resident #77 verbalized pain, yelling and was unable to participate in activities of daily living to include transfers, as her legs buckled beneath her and refusal to eat. First dose of narcotic pain medication was administered on 8/13/24 at 7:19 PM.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 14, 2024 on August 21, 2024 at 1:00 p.m. As of the exit date, August 28, 2024, the immediacy was not removed.

The facility identified a census of 31 residents.

Findings Include:

The Nurse Assessment of Activities of Daily Living (ADL) for Resident #77 revealed total dependence for bed mobility, transfer and toileting with 2 staff assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 697		F 697		

Continued From page 121

The Clinical Resident Profile for Resident #77 listed her as her own responsible party.

The Baseline Care Plan lacked direction for staff to address ADL's and pain.

The Care Plan with a focus of acute pain dated 8/14/24 documented a goal for the resident to be free of pain. It also listed interventions directing staff to evaluate pain and to evaluate for non-verbal indicators of pain.

During an interview on 8/19/24 at 3:21 PM, Resident # 77 stated when she was admitted to the facility the staff did not provide the pain medication she needed for her hips, back and knees. Resident #77 stated, "I cried and cried, it was the worst pain".

The Hospital Discharge Records dated 8/7/24 for Resident #77 revealed:
a. Diagnosis of hemorrhagic shock (severe blood loss), pulmonary embolism (blood clot in lung), and hypoxic (lack of oxygen) respiratory failure due to COVID.
b. Daily activity participation is limited by weakness, decreased activity tolerance and pain.
c. Plan: to provide skilled occupational therapy.
d. Patient currently takes hydrocodone-acetaminophen 5 mg (milligrams)-325mg (Oxycodone)
1 tablet every 6 hours prn (as needed) for pain.

The Progress Notes for Resident #77 revealed:
a. Admit on 8/7/24 at 5:18 pm with pain score in both knees 10/10 (0 no pain to 10 worst pain on the verbal pain scale). Oxycodone was not available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 697	Continued From page 122	F 697		

b. On 8/8/24 resident collapses to the floor when 2 Certified Nursing Assistant's (CNA's) attempted to stand, pivot, and transfer Resident #77 to a wheelchair. Several attempts to stand, resident was unable due to pain therefore a mechanical lift was used to place Resident #77 into the wheelchair.
c. On 8/9/24 Resident #77 cried and yelled in pain during care.
d. On 8/10/24 the provider was notified that the facility was unable to obtain the narcotic as ordered. Received a new order for Tylenol.
e. On 8/11/24 at 9:54 a.m. the Tylenol was administered.
f. On 8/12/24 Resident #77 had continued pain and demanded surgery for her back.
g. On 8/13/24 at 7:19 p.m. Oxycodone was received from the pharmacy and administered.

The Medication Administration Record (MAR) for Resident #77 revealed:
a. Hydrocodone-Acetaminophen (Oxycodone) 5-325 MG ordered 8/7/24 at 1:15 p.m.
b. Oxycodone was not administered 8/7/24 through 8/12/24.
c. Acetaminophen (Tylenol) 650 mg every 4 hours prn pain ordered on 8/15/24 at 8:15 a.m.
d. Tylenol 650mg administered on 8/11/24 at 9:54 a.m. for pain rated 8/10.
e. Tylenol was not administered on 8/12/24.
f. Tylenol 650mg administered on 8/13/24 at 2:24 p.m. for pain rated 4/10.
g. Oxycodone administered on 8/13/24 at 7:19 p.m. for pain rated 6/10.
h. Oxycodone administered on 8/14/24 at 9:49 a.m. for pain rated 10/10.
i. Tylenol 650mg administered on 8/14/24 at 2:24 p.m. for pain rated 4/10.
j. Pain assessment BID (two times a day) initiated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 697	Continued From page 123	F 697		

the evening of 8/9/24, check mark and initial by nursing staff lacked a resident rate of pain at the time of assessment.

During an interview on 8/21/24 at 1:58 p.m. Staff P, CNA stated Resident #77 would initiate the call light multiple times in a shift, requested to have her legs rubbed and repositioned. Staff P stated Resident #77 said "ow when barely touched". Staff P stated it hurt the resident when she was repositioned, turning and during incontinent care. Staff P stated she reported the complaints of pain to Staff R, Licensed Practical Nurse (LPN).

During an interview on 8/22/24 at 12:42 p.m., Staff A, Registered Nurse (RN) stated she reported to the Staff E, Director of Nursing (DON) that the medication for Resident #77 was not accessible for 3-4 days after her admission. Staff A stated the DON responded that she had "done her part" and was waiting for the physician and pharmacy to communicate. Staff A stated the facility did not have a working fax machine to receive a script from the physician then fax that order to the pharmacy to receive a confirmation number in order to remove the medication from the emergency kit at the facility that contains the Oxycodone pain medication that Resident #77 required for pain relief. Staff A stated she was assisting Staff J, CNA to reposition Resident #77 who experienced pain and could not eat due to the pain. Staff A stated Staff Q, LPN utilized a standing order for Tylenol to be administered for the pain. Staff A stated she was aware Resident #77's legs collapsed, lowering the resident to the floor, during multiple attempts to transfer her to a wheelchair due to pain and weakness.

The policy titled Change of Condition/Incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 697

Continued From page 124

Reporting dated 8/2023 revealed when a resident exhibits a change of condition, actions will be taken to coordinate care to meet resident needs.

The policy titled Medication Administration Guidelines dated 10/2023 revealed:
a. Transcribing: ensure accurate transcription and documentation of medications from physician telephone orders, faxed orders, etc.
b. Dispensing: communicating with the pharmacy to ensure accurate and timely delivery of medications.
c. Monitoring: assessing and evaluating the resident's responses to medication and therapy.

F 725 SS=L

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 §483.71.

§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:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 725		F 725		

Continued From page 125
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 observation, interview, and record review the facility failed to ensure sufficient staffing to provide all necessary cares and supervision to residents who resided in the facility per resident needs for 31 of 31 residents who resided at the facility. Facility staff reported calling 911 due to lack of adequate staffing at the facility.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 19, 2024 on August 25, 2024 at 6:15 p.m. As of the exit date, August 28, 2024, the immediacy was not removed.

The facility identified a census of 31 residents.

Findings Include:

On 8/21/24 at 11:09 a.m., during an interview with Staff B, Certified Nursing Assistant (CNA), Staff B explained the following about staffing: Basically the only thing that could get done was make sure people didn't get out of the building. When queried if there were fall risks, Staff B responded yes. When queried if able to adequately supervise with just herself as a staff person, Staff B responded, no.

On 8/21/24 at 2:34 p.m., during an interview with Staff G, CNA, Staff G explained the facility had been having [Former Administrator Name

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 725		F 725		

Continued From page 126

Redacted] as the second person, and it really needed to be another CNA. Per Staff G, there should be two CNA for the unit and 2 CNAs up front (East and West halls). When queried if she was able to keep everyone safe, Staff G responded she did not feel safe in the unit (CCDI unit). Staff G responded she thought an incident between two residents was on a second shift, explained it could be very draining, and explained being ready to go home at the end of shift.

On 8/22/24 at 9:42 a.m., during an interview with Staff L, former Regional Nurse Consultant (RNC), Staff L explained there had been multiple conversations about staffing of the facility.

On 8/22/24 at approximately 11:30 a.m., during an interview with Staff C, Certified Nursing Assistant (CNA), Staff C explained she did not usually work the dementia area much, and was usually staff member in the front (East and West halls) by self and person in the back (noted to be where CCDI unit located) by themselves. Per Staff C, lately trying to staff two. When queried if she could get everything done when staffing was one and one, Staff C explained for a week and a half to two weeks did not do showers because of behaviors and no one to help. Staff C explained they had just started giving showers a week ago. Staff C explained not enough help and constantly running.

On 8/22/24 at 11:41 a.m., Staff C further explained approximately two weeks ago, [Staff E, Former DON Name Redacted] was the nurse, and Staff C was in the dining room. Per Staff C, one of the residents started choking, Staff C was over with the resident and was yelling for the [Former DON, Staff E]. As Staff C was yelling for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 725	Continued From page 127	F 725		

[Staff E], another resident got up and running out of the dining room. Staff C explained as one person, she (Staff C) had no way of controlling any of it. When queried about the resident who was choking, Staff C explained the resident was fine. Staff C explained the resident who choked was Staff C's first one to ever choke, explained the resident started coughing, Staff C patted the resident on the back, the resident started "jerking real hard", and explained resident cleared it. Staff C further explained during the time another resident was walking without their walker. When queried if there was supposed to be a nurse in the dining room during meals, Staff C responded never, is just me (Staff C).

On 8/25/24 at 10:56 a.m., Staff B, CNA interviewed and observed to be present on CCDI unit. Staff B explained she came in at 6 (a.m.), and other staff member, explained as MDS Coordinator wasn't present until 7.

On 8/25/24 at 2:53 p.m., Staff Q, Licensed Practical Nurse (LPN) explained facility did not always have two (staff) on the CCDI unit, and when they did was a "kid from the kitchen".

On 8/25/24 at 4:41 p.m., the State Agency placed a call to the Regional Vice President (VP) of Clinical for Beacon Health Management, to notify her that an IJ had been determined for F725 and F726. The Regional VP served as the contact person due to the previous administrator removed from the building on Friday 8/23/24 and a new administrator to be present at Donnellson on Monday 8/26/24. The SA notified the Regional VP that facility staff were reporting to surveyors onsite in interviews that they would have to use support, unlicensed personnel in the morning as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 725	Continued From page 128	F 725		

they did not have enough staff. The Regional VP reported that they would have the appropriate staff and she would begin calling agency staff to cover the overnight shift and cover Monday morning shifts. The Regional VP reported that would mean 1 nurse for the front hallways and 1 nurse for the CCDI unit and 2 aides in the front and 1 aide in the back.

On 8/25/24 at 4:50 p.m., Staff H, CNA explained on Friday (8/23/24), she was by herself for the whole building from 2p.m. to 6a.m. Staff H explained up front there were six residents who required two person assist, five of whom required hoyer (mechanical lift). Staff H named the nurse that worked. Staff H explained the following: Staff H came in at 2, and gave till 2:30 when no one showed up. Staff H explained someone stayed till 4:30 PM, which left the nurse on the unit and Staff H up front. Staff H explained no residents who required hoyer lift gotten up because she could not do it by herself. Per Staff H, she put everyone to bed up front, and then her and the nurse switched., and then put the dementia unit residents to bed. When queried about falls, Staff H explained there had been three falls: For one resident, she heard yelling from the room, for another resident she had been putting someone to bed and heard bang, and came out, and third resident she was not there and heard from the nurse. Per Staff H, the bosses were aware. The Director of Nursing (DON) was in [city name redacted], the Administrator had not fully started yet and was aware and did not come in. Staff H explained she texted the Administrator, who said to ask people to come. Staff H explained she did that, and response was no, can't. When queried how she handled the meal, Staff H explained passed people who eat by self, the ones

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 725	Continued From page 129	F 725		

(residents) who required hoyer (lift) didn't get up, then persons who required one assist, then room trays for those residents who required hoyer (mechanical lift).

During an observation on 8/26/24 at 5:25 a.m. Staff R, Licensed Practical Nurse (LPN) worked on the East and West halls as the lone staff for 17 residents. Six (6) of the 17 residents required the assistance of two staff for their care. The CCDI unit (Chronic Confusion or Dementing Illness) staffed with Staff K Certified Nursing Assistant (CNA,) as the lone staff for the 14 residents on the unit.

During an interview on 8/26/24 at 5:25 a.m. Staff R, LPN, stated she was "exhausted" and did not have a working fax machine to send the daily sheets to the corporate office. Staff R stated the Agency CNA that was scheduled for the day shift called in at 3 a.m., she had notified the Director of Nursing (DON) by a text that she would not have a day shift CNA. Staff R stated she felt like she had Post Traumatic Stress Disorder (PTSD) due to the stress, anxiety and worry for her nurse licensure. Staff R was tearful and stated that there were no falls during the night but was unable to complete the skilled assessments for the 5 skilled residents. Staff R stated she worked multiple days and did not remember the last time she completed the skilled assessments. She stated she did not have time to follow up on falls and did not have a second person to assist the residents who were a maximum assist of 2 staff. Staff R stated she had brought Resident #16 out to the living room area during the night as he was a fall risk and needed monitoring. Staff R stated the staff called 911 for help on 8/24/24 due to no staff on evening shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 725	Continued From page 130	F 725		

Continuous observation on 8/26/24 of the nursing station area between East and West hall revealed:
a. At 5:25 a.m., in front area (East and West hall), Resident #16 sat in a recliner wearing a tee shirt and boxers over incontinent product (brief).
b. At 6:00 a.m., Staff S, Corporate Recruiter entered the CCDI unit.
c. At 6:06 a.m., DON entered the building. Staff R reviewed the situation regarding lack of staff. Both Staff R and the DON entered the CCDI unit with no staff to monitor the 17 residents on the East and West Hall, and fall risk Resident #16 in the recliner.
d. At 6:07 a.m., Resident #16 in the recliner swinging legs in an apparent attempt to get out of the chair.
e. At 6:10 a.m., Staff R returned with the DON, sent a text to the Regional Nurse Consultant (RNC) asking for assistance.
f. At 6:13 a.m., Staff R exited the building.
f. At 6:20 a.m., the DON stated she did not know where to start. Then walked into the East hall to conduct a visual check on each room. The West hall not checked.
h. At 6:23 a.m., Staff T, Housekeeping Supervisor entered the building.
i. At 6:51 a.m., the Administrator entered the building and attempted to answer a call light but could not locate the source.
j. At 6:55 a.m., The Regional Nurse Consultant (RNC) entered the building, entered the Dementia unit and Staff S attempted to locate the call light source, which was located 5 minutes later after searching all rooms in East hall.
k. At 7:11 a.m., the DON and Staff S entered a room with the mechanical lift.
l. At 7:19 a.m., the Administrator returned to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 725		F 725		

Continued From page 131

nurses station stating another CNA quit and the Agency sent a CNA from a town an hour and half away.
m. At 7:29 a.m., 2 housekeepers in living area and asked Resident #16 if he was "doing exercises", when he swung his legs in the air attempting to get up.
n. At 8:01 a.m., The DON and Staff S assisted Resident #16 out of the recliner, visibly wet, and transferred to a wheelchair and housekeeping cleaned the recliner and mopped the floor.

On 8/26/24 at 9:02 a.m., the Regional Vice President of Clinical Operations contacted the State Agency and reported the staffing agency lined up called off and did not show up to work. The Regional Vice President voiced she had no idea what else to do but to start evacuating residents and it would not be a popular decision with her corporation representatives above her but she felt she had no choice as they could not meet resident needs with the current staffing levels.

During an interview on 8/27/24 at 11:32 a.m., Staff T, Housekeeping Director stated the housekeeping staff do what they can to help without providing patient care. Staff T stated she tried to keep Resident #16 occupied until the staff could get to him. Staff T stated she had to clean the recliner because Resident #16 was incontinent and "always overflows his brief".

The Daily Assignment Sheet on 8/24/24 revealed:
a. Day shift: Staff Q, LPN nurse 6 a.m. - 6 p.m. Staff J, CNA 6-2 p.m. front (East and West Halls) and Staff U, LPN split shift with Staff A, RN.
b. Afternoon shift: Staff O, LPN 6 p.m. - 6a.m. Staff A, RN 2 p.m. - 6 p.m. as a CNA. At 6:15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 725		F 725		

Continued From page 132
p.m. to 10 p.m. Staff W, dietary staff answered lights, no cares given.
c. Night shift: Staff K, CNA worked in CCDI unit and Staff V, CNA front 10 p.m. to 6 a.m.

During an interview on 8/28/24 at 8:40 a.m., Staff D, Social Services/Activity Director stated on 8/11/24 around 2 p.m. there was no visible staff in the front portion of the building with 17 residents and Resident #77's call light was activated. Staff D stated she took Staff K, CNA who entered the building with her to assist Resident #77 to the bathroom. Staff D stated Resident #77 was too weak and slid to the floor during transfer back to bed. Staff D stated it was not "graceful" but she "scooped" Resident #77's arm and returned her to bed. Staff D stated she would never hurt anyone, but she was not a CNA. Staff D stated Staff N, former Administrator, "forced" management staff to work in the Dementia unit to get residents up, shower them, dress and clean them. Staff D stated "I did what I was told to do, not by my own free will". Staff D stated Staff N worked in the Dementia unit on multiple days and gave care to the residents. Staff D stated the facility did not have enough staff to care for the residents.

Continued observation on the morning of 8/26/24 conducted in the front (East and West halls) portion of the facility revealed the following:

a. 8:09 a.m., residents present in common area at front of the facility near the dining room (DR) area. Housekeeping Supervisor said, "Who wants to be the lucky contestant to go in first, like the [game show name redacted]?" The Housekeeping Supervisor brought a resident into the DR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 725		F 725		

Continued From page 133

b. 8:10 -8:12 a.m., the Administrator and Housekeeping Supervisor asked resident to go to DR/assisted residents to the DR.
c.8:16 a.m., six residents present in the dining room.
d. 8:23 a.m., six residents in the DR do not have food in front of them. Do have drinks present.
e. 8:26 a.m., a resident brought down the hallway backwards in a padded chair.
f. 8:28 a.m., the DON said I will pass a few meds.
g. 8:29 a.m., the kitchen staff observed to be serving food.
h. 8:56 a.m., the Housekeeping Supervisor left the DR. The DON present at the med cart outside of the DR by the nursing desk said, Is somebody in there (DR)? Housekeeping Supervisor observed in the hallway getting an item. It was noted the DR had a more standard sized opening to access the DR, so when outside of the DR, line of sight for all residents in DR would be obstructed.

It was noted upon arrival to the facility for the facility's recertification survey on 8/19/24, the facility reported census of 31 residents. Of the 31 residents, 5 residents payor source Medicare, 5 residents payor source Medicaid, and 12 residents payor source other.

Per the Resident List Report provided by the facility, 14 residents resided on the North unit, noted to be the facility's CCDI unit.

Review of the Facility Assessment revised 7/8/24 revealed the following: Areas Facility Assessment Informed chart included a line for staffing. Action to be taken/already taken this year for staffing row included, adjust PPD (per patient day) to reflect resident needs. Per the Facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 725	Continued From page 134	F 725		

Assessment, the facility had 46 licensed beds with average daily census(range) documented as 20, noting number affected by facility closure.

The section of the Facility Assessment titled Assistance with Activities of Daily Living (ADL) revealed the following number (ranges) of resident's dependent for ADLs: Dressing 1-2, bathing 1-2, transfer 1-3, eating 1, toileting 1-2. The Mobility section revealed 1-11 residents in chair most of the time.

The Staff/Plan Table of the Facility Assessment revealed the following for Licensed Nursing: DON (Director of Nursing): 1 DON RN (Registered Nurse) full time days, and if had other responsibilities add "x" more RN as Asst. (assistant) DON to equal one FTE (full time employee). Plan: DON full time w/ (with) two Licensed Nurses (12 hr shifts). RN or LPN (Licensed Practical Nurse) Charge Nurse: 1 for each shift. 1-"x" residents DON may be Charge Nurse, 1-"x" Licensed Nurse ratio days and evenings and same for nights.

The Direct Care Staff section revealed the following plan:

Plan: CCDI (chronic confusion dementing illness) 1:8 ratio days, 1:8 evenings, 1:16 nights. SNF (skilled nursing facility)/LTC (long term care): 1:10 days, 1:10 evenings, 1:20 nights).

The Facility Assessment also revealed the following full-time employees required per the Other section: maintenance full time/on call, housekeeping/laundry supervisor fulltime with 2 additional fulltime staff, dietary: DSM (Dietary Services Manager) full time with one additional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 725		F 725		

Continued From page 135

full time day cook and two full time cooks, one dietary aide per shift and a full time activities/social services director, and a full time business development individual.

The Staffing Assignment section of the Facility Assessment revealed, Attempt made to keep consistent staff assigned to areas of the facility specifically the CCDI unit. This is reviewed at time of schedule posting and staff strengths for placement in specialized areas is discussed with IDT (interdisciplinary) team.

Review of Resident Council Meeting Notes revealed the following:

a. 5/31/24: Nursing-doing ok, but sometimes it's a long wait for call lights to be answered.
b. 7/26/24: Waiting on call lights but know staff is busy.

On 8/26/24 at 9:48 a.m., the Regional Vice President of Operations explained 13 residents would be transferred out to sister facilities, the only residents left would be in the closed unit, and could staff for that.

On 8/26/24 at 4:58 p.m., Staff N, former Administrator, explained she came in on weekends and tried to help cook as the main cook would not come in for next six weekends. Staff N explained between the [Housekeeping/Laundry Supervisor] and herself, they did the best they could.

Per Staff N, regarding PPD (per patient day) and staffing issues, there were months and months of emails begging for help. Per Staff N, she was told by [higher level corporate staff member] that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET** **DONNELLSON, IA 52625**

(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 725	Continued From page 136 agency would not be paid, and would fix using agency because would not pay them. Per Staff N, [agency name redacted] could not use because would not pay them. Staff N explained the following about CNAs in the building: Per Staff N, was told with 24 residents would be 8 CNAs, 3 days, 3 second shift, 2 overnights. Staff N explained then moved to only 6, 2 days, 3 for nights, and 1 overnight. Per Staff N, she said not doing 1 staff. Per Staff N, response provided to her was could go over what-ifs all day long. Staff N further explained she was told could have 2 for overnights, but would have to take a staff member from days. When queried how would then cover, Staff N explained leadership would have to take shifts back there. Staff B explained one certified person in the back and one non-certified could be anybody. Staff N explained the facility was like having two separate facilities, and needed common staff because need to know resident routines. Per Staff N, a call occurred with [management staff], was communicated that have had enough of your PPD (per patient day), would not be signing off on PPD until understood exactly what the facility had been cited for. Per Staff N, was told if increased census would get more staff. Per Staff N, access to recruiting software had been taken away from Staff N, former Administrator as it wasn't their job to recruit CNAs. Staff N explained they had been without a maintenance man since mid June, and there were 23 applicants for maintenance. On 8/28/24 at 8:46 a.m. during an interview with the current Interim Director of Nursing (DON), the DON explained the facility had attempted agency since she got to the facility, and the two times agency had someone for the facility the staff had not shown up. Per the DON, the facility was	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 725 Continued From page 137 F 725

recently looking to sign new contracts with new agencies. When queried about staff working in excess of the amount of hours in their shift, the DON explained CNAs and nurses she thought both had worked over their 12 or 8, she thought related to both staff not showing up and needing to stay, and explained she had done the same. When queried about herself (DON) working long hours/how long, the DON explained she had been on for 34 hours, did have a couple 2- or 3-hour breaks, this was right before State Agency got to the facility, and nobody would come in/answer the phone. Per the DON, corporate was calling and texting people trying to get other facilities to come. Per the DON, it was an ongoing battle and was worse and worse.

The Facility Policy titled Clinical Staffing Standard dated 12/23 revealed the following Standard: To provide nursing services regarding licensed nurses and certified nursing assistants 24 hours daily in order to meet the care and service needs of residents that reside in the facility. The Policy also revealed, Agency staff will only be utilized when absolutely necessary and agency personnel will follow all policies and procedures of the facility assigned.

F 726 SS=L Competent Nursing Staff F 726
CFR(s): 483.35(a)(3)(4)(c)

§483.35 Nursing Services
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 726	Continued From page 138	F 726		

and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and record review, the facility failed to ensure there were competent staff to provide care for a resident's drains and wound vac. Following a hospital stay Resident#78 had a wound vac (dressing with a pressurized devise), and two bulb type drains. The facility failed to provide cares to the wound vac, and drains per surgeon orders due to staff claims of lack of training to provide the needed treatment. The facility continues to not provide cares to the wound vac and drains upon exit of the survey. Staff also lacked knowledge on how to care for Resident#79's biliary catheter (the catheter placed in the common bile duct to drain bile from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 726		F 726		

Continued From page 139
the gallbladder and liver). Uncertified staff had also provided cares to residents on multiple occasions.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 21, 2024 on August 25, 2024 at 6:15 p.m. As of the exit date, August 28, 2024, the immediacy was not removed.

The facility identified a census of 31 residents.

Findings Include:
During an observation on 8/19/24 at 3:39 p.m., Resident #78 had a surgical wound to her left side with a wound vac set on a continuous setting and 2 drains from the abdomen to bulbs with a scant amount of drainage on left and small amount on the right. Resident #78 was found to have suffered with nausea and vomiting for several days and untreated pain.
The Physician's order for Resident #78 revealed:
a. Wound vac on upper left flank change 3 times a weekly on Wednesday, Monday, Friday, setting at 125mmHg suction, with foam dressings black and white.
b. Lack of an order for treatment for the abdominal drains (right and left) dressing change nor when to empty.
The Treatment Administration Record for Resident #78 revealed:
a. The wound vac dressing was changed last on 8/16/24.
b. Lack of documentation of drainage from wound vac.
c. Lack of documentation for the right and left drains for a dressing change and measurement of drainage bulbs.
The Hospital Discharge document dated 8/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 726	Continued From page 140	F 726		

with instructions for drain care reveal:
a. Flush both drains with 10 ml saline twice a day (BID), measure drainage.
b. When drainage decreased to 5 ml notify the surgeon office for an appointment for drain removal.
During an interview on 8/21/24 at 3:44 p.m., Staff O, LPN stated the admission orders for Resident #77 was "all screwed up", she had pain, an order for oxycodone and was unable to access it. Staff O stated she also had a dressing to her neck and no one was aware of what that was. Staff O stated she did not have a required lab order for Resident #78 to monitor the injectable blood thinner. Staff O stated she did not know Resident #78's diagnosis or that the drains needed flushed, dressings that needed changed and the Zofran medication for nausea was scheduled 3 at a time, that order was as needed (PRN). Staff O stated she was not familiar with Resident #79's biliary catheter (the catheter placed in the common bile duct to drain bile from the gallbladder and liver) that needed a dressing change and the dressing on his catheter was dated before admit. Staff O stated she found it 2 weeks later and the dressing was black from the fluid that was leaking out and around the catheter. Staff O stated "I had to google the procedure to change the dressing and the drainage was probably bile". Staff O stated she did not report it to the physician as the DON informed her that it would be taken care of in the morning. Staff O stated there were no orders for the dressing or the drain. Staff O stated, "We obviously knew it was there".

During an interview on 8/26/24 at 5:25 a.m., Staff R, LPN, stated that there were no falls during the night but was unable to complete the skilled assessments for the 5 skilled residents. Staff R

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 726	Continued From page 141	F 726		

stated she worked multiple days and did not remember the last time she completed the skilled assessments and did not have time to follow up on falls. Staff R stated the nurses are in a disagreement with who can change the dressing for Resident #78's wound vac and flush the drains so it was still not been done.

During an interview on 8/28/24 at 8:40 a.m., Staff D, Social Services/Activity Director stated on 8/11/24 around 2 p.m. there was no visible staff in the front portion of the building with 17 residents and Resident #77's call light was activated. Staff D stated she took Staff K, CNA who entered the building with her to assist Resident #77 to the bathroom. Staff D stated Resident #77 was too weak and slid to the floor during transfer back to bed. Staff D stated it was not "graceful" but she "scooped" Resident #77's arm and returned her to bed. Staff D stated she would never hurt anyone, but she was not a CNA. Staff D stated Staff N, former Administrator, "forced" management staff to work in the Dementia unit to get residents up, shower them, dress and clean them. Staff D stated "I did what I was told to do, not by my own free will". Staff D stated Staff N worked in the Dementia unit on multiple days and gave care to the residents. Staff D stated the facility did not have enough staff to care for the residents.

During an interview on 8/22/24 at 9:09 a.m., Staff L, former Regional Nurse Consultant (RNC) stated she was made aware that non-certified staff was providing certified nursing assistant care to residents in the Dementia unit and had conversations with the DON, Administrator and the corporate office of what a certified vs non-certified staff person could do. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 726	Continued From page 142 expectation was that unless it was an emergency, only the certified staff could touch a resident.	F 726		
F 741 SS=J	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents 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 §483.71. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.71, and §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure resident behavioral health needs were included in resident plan of care. Resident #23 with short stay PASARR Level II had expressions of suicidal ideation via hanging self with a rope and severe	F 741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 741		F 741		

Continued From page 143
depression known via hospital records prior to admit to the facility. Resident #11 with PASARR Level II which included history of cutting voiced to staff to secure razor blades, then later brought razor blades and scissors to staff and said not to have such items. Resident #2 PASARR failed to list mental health diagnoses.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 09, 2024, on August 26, 2024 at 3:15 p.m. As of the exit date, August 28, 2024, the immediacy was not removed.

The facility identified a census of 31 residents.

Findings include:

1.The Admission Minimum Data Set (MDS), dated 7/02/24, revealed Resident #23 currently considered by the State Level 2 Pre-Admission Screening and Resident Review (PASRR) to have serious mental illness, intellectual disability, or related condition. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15 to indicate moderate cognitive impairment. MDS assessment documented that Resident #23 had symptoms of feeling down, depressed, or hopeless, without a frequency of mood symptoms indicated. Behavioral symptoms included verbal behaviors, directed at others, and other behavioral symptoms, not directed at others, that interfered with Resident #23's participation in activities or social interactions. MDS indicated that Resident #23 required antipsychotic medication on an as needed only basis. Resident #23 able to transfer and ambulate independently throughout the facility. Diagnoses included Cerebral Vascular Accident (CVA or stroke),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 741	Continued From page 144	F 741		

non-Alzheimer's dementia, depression, and cirrhosis of the liver.

A Baseline Care Plan with admission the date, 6/26/24, revealed Resident #23 at risk for elopement and noted that Resident #23 was a smoker prior to admission but had not been out to smoke. The Baseline Care Plan lacked identification of mood or behavioral symptoms upon admission.

A Hospital History and Physical (H&P) Report, dated 6/01/24, revealed Resident #23 voluntarily admitted self to hospital via the Emergency Department (ED), due to reporting suicidal ideation and then admitted as inpatient to the hospital psychiatric unit. Resident #23 had a history of similar inpatient stays with 4 other admissions since 2022. Past Medical History included diagnoses of suicidal ideation and severe, recurrent, Major Depressive Disorder (MDD) without psychotic features. The H&P revealed Resident #23 reported feeling very depressed with plans to hang himself, and went as far as to buy the rope to do so but stated he stopped as he could not find a tree suitable to do so. Resident #23 additionally reported worsening anxiety symptoms such as palpitations, chest heaviness, dyspnea (difficulty breathing), and racing thoughts, contributing to a lack of sleep, as well as visual hallucinations of bugs on the wall.

A Hospital Behavioral Progress Note, dated 6/24/24, revealed Resident #23 continued to endorse feelings of helplessness and remained appropriate for inpatient psychiatric treatment due to suicidal ideation in the setting of medical comorbidities and poor self-care. Disposition likely to be nursing home level of care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 741	Continued From page 145	F 741		

Continued From page 145
planned discharge to facility on 6/25/24.

A Pre-Admission Screening and Resident Review (PASRR), dated 6/24/24, identified Resident #23 as a Level 2 with short stay, time limited, nursing facility approval for 365 days due to current functional needs. Mental health conditions included severe, recurrent MDD without psychotic features, and mood disorder with depressive features due to a medical condition. Past mental health symptoms identified on the PASRR included feelings of hopelessness and worthlessness, thoughts of wanting to end life, taking actions to end life, depressed mood, worry, and seeing things that are not real. Noted from a previous PASRR review, dated 6/08/24, Resident #23 had a history of four mental health hospitalizations, in the year 2023, for depressive symptoms and self-harm.
PASRR listed the following services and supports that the admitting nursing facility would be required to provide for Resident #23:
1. Ongoing psychiatric medication management by a Psychiatrist or Psychiatric Nurse Practitioner.
2. Individual therapy by a licensed behavioral health professional.
3. Behavioral health crisis intervention and safety plan.
4. Rehabilitative services.
5. Community placement supports.

The facility Clinical Admission Assessment, dated 6/26/24, revealed that Resident #23 was alert and oriented with some forgetfulness. The Admission Assessment lacked identification of safety concerns related to harm of self or others, and lacked identification of mood or behavioral concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 741	Continued From page 146	F 741		

The Care Plan, revised on 7/11/24, lacked identification of mood symptoms. Care Plan lacked intervention for monitoring and reporting suicidal ideation or expressions of self harm, and lacked Resident #23 behavioral health crisis interventions and safety plan.

A review of the Medication Administration Records (MAR) from June, July, and August 2024, revealed current an order for Mirtazapine 30 milligrams (mg) daily for anxiety started on 6/26/24 and order for a Nicotine transdermal 21mg patch to be applied every 24 hours as needed with start date of 6/27/24 and discontinue date of 7/25/24, no administrations of patch documented.

Review of facility Nursing Progress Notes revealed the following entries:
1. On 7/03/24 at 12:34 PM, facility staff tried to call Resident #23's family for verbal consent of televised psychiatric (tele-psych) services.
2. On 7/10/24 at 8:30 PM, note indicated Resident #23 upset, believed he did not belong in locked unit, and stated his son would be leaving the state soon and felt he had been left at the facility. Resident #23 attempted to call law enforcement on his cell phone.
3. On 7/22/24 at 2:45 PM, facility staff tried to call Resident #23's family for verbal permission of tele-psych services.
4. On 7/27/24 at 5:45 PM, note indicated that Resident #23 had approached nurse and wanted to talk, told nurse he wanted to leave, felt like he was in jail and does not belong at facility. Resident #23 also conveyed frustration about staff telling him what he can and can't do. Nurse documented that Resident #23 was told that he refused showers on a regular basis and if he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 741		F 741		

Continued From page 147
wanted to prove he doesn't belong at facility, he needed to take care of his business, such as hygiene and activities of daily living.
5. On 7/29/24 at 1:41 PM, staff reported to nurse that Resident #23 threatened and hit his roommate in the common area.
6. On 8/01/24 at 9:45 PM, Resident #23 approached nurse and asked for his cigarettes, when nurse told him he could not have because he had been caught smoking in the building, resident became upset and smacked the glass window, he stated facility was holding him hostage and he wanted to leave. Nurse documented the assumption that Power of Attorney (POA) was in place, and charted that family does not want him, indicated maybe Resident #23 could go to an apartment.

The Patient Health Questionnaire (PHQ-9) assessment, used for determining the severity of depression, dated 7/29/24, revealed a score of 9, or minimal symptoms of depression. The assessment indicated Resident #23 felt down, depressed, or hopeless nearly every day and had thoughts of being better off dead or hurting self in some way nearly every day. Assessment had box that remained unchecked to inform responsible staff or provider of a potential for resident self harm.

Televised Psychiatric (tele-psych) Provider note, dated 8/01/24, revealed Resident #23 asked staff for a referral to counseling. Resident #23 was a new referral being seen for depression, withdrawal, isolation, agitation, confusion, grief/loss issues, family related issues, alcohol or substance abuse, verbal and physical aggression, and sexually inappropriate behavior. Note indicated Resident #23 had history of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 741		F 741		

Continued From page 148

passing suicidal thoughts but none recently. Treatment plan to address adjustment, attention, interpersonal problems, and substance abuse.

On 8/19/24 at 11:09 AM, Resident #23 observed with long unkempt hair and long beard, wearing sweatpants noted to have stains, and shoes that did not appear to fit resident correctly, as he walked on the backs of heels.

On 8/19/24 at 2:50 PM, Resident #23 walked out of his room to dining room, holding clothing, and asked Certified Nursing Assistant (CNA) if he could take a shower, CNA agreed and went to assist resident.

On 8/28/24 at 8:04 AM, current interim Director of Nursing (DON) informed that she had been in position at facility for a short time, therefore did not have sufficient knowledge on Resident #23's mental health conditions but did reveal the expectation that any history of suicidal ideation or expressions of self harm be documented in a resident's plan of care as well as interventions to ensure a residents safety. The DON also revealed the expectation that any PASRR level 2 supports and services a resident required be included in the plan of care and facility implementation of such services as a team effort to the best of facility's ability.

The facility policy titled, Behavioral Management Standard, dated October 2023, revealed the expectation that residents in specialty units have behavior intervention plans to improve life skills and quality of life. Policy instructed staff to complete a thorough evaluation and examination of resident's mental status with review of resident medical history and condition. The policy also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 741 Continued From page 149 F 741

revealed the expectation for staff to identify resident targeted behaviors and specify interventions, through care planning, to be used by staff when behavior is present.

The facility policy titled, Pre-Admission Screening and Resident Review (PASRR), dated August 2022, revealed the purpose of policy to assure that psychological, psychiatric, and functional needs are considered in long term care and listed the Social Services Director as accountable for this process.

2. Review of Resident #11's Minimum Data Set (MDS) assessment dated 6/1/24 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident had a diagnosis of schizoaffective disorder, bipolar type.

Review of the resident's PASARR dated 2/9/24 revealed Resident #11 had a Level II PASARR with short term stay approval. Per the PASARR Level II, the following specialized services were needed: Ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner, a crisis intervention/safety plan, a Power of Attorney, a referral for integrated home health, a referral or application for eligibility determination for Medicaid coverage including Home and Community Based (HCBS) waivers, an occupational and physical therapy screening, and obtaining psychiatric/behavioral health treatment records. The resident required the following community placement supports: home health nurse and aide services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 741	Continued From page 150	F 741		

The resident's PASARR Level II dated 2/9/24 revealed, you have a history of having behaviors in which you would harm yourself by cutting.

Review of Resident #11's Baseline Care Plan dated 2/22/24, locked on 2/24/24, revealed the following per the Social Services Section:

a. Monitor for changes for Behavioral issues.
b. No PASARR II needed.

Review of Resident #11's Comprehensive Care Plan lacked history of self harm or mention any specific guidance involving razor blades for this resident.

The Care Plan dated 3/5/24 revealed, [Resident #11] requires observation with Activities of Daily Living (ADL's) related to (r/t) Dementia, schizophrenia. The Intervention dated 3/5/24 revealed, BATHING/SHOWERING: [Resident #11] is able to do own shower twice a week.

Review of the 6/22/24 at 11:00 AM revealed, in part, [Resident #11] also placed herself in between staff this morning and asked that the shower cabinet be locked (it is always locked) because it has razors in it and she has a history of self harm. [Resident #11] was asked twice if she wanted to hurt herself or others and she stated no. The shower room door has a code entry and staff advised not to open the door if [Resident #11] is close so she cannot observe the number code. Power of Attorney (POA) has not called back, so another message was left to contact the facility or myself directly. Additional staff notified and an unplanned psych appointment will be made via telehealth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ___ B. WING ___	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 741	Continued From page 151	F 741		

Review of the Health Status Note dated 7/15/24 at 2:16 PM revealed, [Resident #11] was going through her belongings and found scissors and razors and gave them to staff today. States she does not want to have anything in her room she is not allowed to have. Her items were labeled with her name and placed in the nurse's room.

Review of Progress Notes for Resident #11 between 6/22/24 and 7/15/24 did not include any additional information about the resident's comment on 6/22/24/individualized interventions for this resident.

Observation during time of survey revealed Resident #11 was independently ambulatory in the front (outside of the chronic confusion dementing illness) part of the facility.

On 8/28/24 at 8:50 AM, the Interim Director of Nursing explained PASARR Level II specialized services would be implemented by social services and was a team effort.

The Facility Policy titled Behavioral Management Standard, dated October 2023, revealed, Behavior Management Program will consist of... Ensuring a thorough and comprehensive assessment of the residents' needs, behaviors, and prior medications and medical history utilizing approved standard assessment tools.

3. The Minimum Data Set (MDS) assessment, dated 6/05/24, revealed a Brief Interview for Mental Status (BIMS) score for Resident #2 of 9 out of 15, indicating moderate cognitive impairment. Diagnoses included: complete traumatic amputation of leg lower extremity,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 741	Continued From page 152	F 741		

non-Alzheimer's dementia, depression, Diabetes Mellitus, Peripheral Vascular Disease (PVD), and pruritis (itchy skin). MDS indicated Resident #2 had one venous/arterial ulcer present as well as skin tear(s). Resident #2 required antipsychotic medication on a daily basis.

The Care Plan, revised 7/26/24, revealed a Focus Area for open wounds on abdomen and leg. Care Plan informed that Resident #2 required course of antibiotics started on 7/12/24 due to picking at wounds and causing skin damage. Care Plan also revealed that on 8/08/24, Resident #2 picked off her toenail and created a wound. Interventions instructed staff to use an abdominal binder and dressings to help prevent Resident #2's picking and follow wound care instructions. The Care Plan lacked focus area for impaired cognition, behavioral symptoms, depression diagnosis, or use of psychotropic medication. The Care Plan additionally lacked indication for behavior monitoring or additional interventions for preventing self harm of skin, other than abdominal binder.

A Pre-Admission Screening and Resident Review (PASRR), dated 9/30/2014, revealed no mental illness diagnoses or psychiatric treatment history. One medication, Amitriptyline 100 milligram (mg) per day, listed for depressive disorder. No additional PASRR submissions available for review.

In a Discharge Summary from previous facility, dated 5/29/24, Resident #2 had additional diagnoses that included Obsessive Compulsive Disorder and the Multi-Drug Resistant Organism (MDRO): Carbapenem-Resistant Acinetobacter Baumannii (CRAB) . Infection Transfer form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 741	Continued From page 153	F 741		

indicated Resident #2 would require Enhanced Barrier Precautions due to MDRO and open wounds.

Review of Resident #2's facility listed diagnoses, dated 8/28/24, lacked identification of Obsessive Compulsive Disorder or CRAB.

The Medication Administration Record (MAR), dated August 2024, revealed order for antipsychotic medication Quetiapine (Seroquel) 50 milligrams (mg) to be given three times a day for agitation, aggression, and exit seeking, started on 6/23/24 and changed to 75mg to be given daily at bedtime for dementia diagnosis on 8/06/24.

Review of Nursing Progress Notes, revealed the following entries:
1. On 5/29/24 at 6:00 PM, Nursing required to change abdominal dressing 4 times since admission due to Resident #2 constant digging at open wounds.
2. On 6/01/24 at 1:09 PM, Resident #2 picked at skin, twisted and ate hair. Nursing indicated behaviors greatly decreased after dosage of antipsychotic medication.
3. On 6/05/24 at 11:28 AM, Resident #2 picked scabs on legs until bleeding, nursing documented application of wound dressings, covered with tubigrips and application of gloves on Resident #2 to lessen picking skin and hair.
4. On 6/15/24 at 02:44 AM, Resident #2 observed scratching deeply at abdominal wound, causing it bleed and then trying to suck fingers. Nursing documented skin surrounding wounds appeared more irritated and indicated wounds would be assessed the following day.
5. On 6/24/24 at 3:28 PM, A referral sent to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 741	Continued From page 154	F 741		

Televised Psychiatric (tele-psych) Provider.
6. On 7/05/24 at 9:05 AM, Resident #2 picked open wounds on abdomen.
7. On 8/03/24 at 6:45 AM, Resident #2 observed sitting on edge of bed, picking at wounds and putting the debris in her mouth. Nursing also documented that during the night shift Resident #2 pulled her toenail off and found sucking on it. Nurse noted that Resident #2 had been educated daily not to pick at wounds.
8. On 8/06/24 at 2:40 PM, order received to change antipsychotic medication dosage from 50mg three times a day to 75mg at bedtime.
9. On 8/20/24 at 1:58 PM, Resident #2 seen by Psychiatry.

On 8/19/24 at 2:35 PM, Resident #2 sat on couch in common area, staff asked her if there was a reason her glove was off, commented that Resident #2 had picked off abdominal wound, and instructed resident to put glove back on.

On 8/20/24 at 2:24 PM, Resident #2 in wheelchair outside of room 8, picking at the wall. Noted a large area of missing paint and drywall with flakes and debris on the handrail and floor.

On 8/21/24 at 2:12 PM, Staff G, Certified Nursing Assistant (CNA), revealed that Resident #2 often picks at stomach and leg and eats scabs. Staff G stated Resident #2 lost her left leg (amputation) because of picking behavior.

On 8/21/24 at 3:02 PM, Staff I, CNA, revealed that Resident #2 picks at herself and informed that intervention to prevent picking included abdominal band. Staff I stated there's currently an area on her right ankle that she's also picked open.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 741	Continued From page 155	F 741		

On 8/28/24 at 8:04 AM, current interim Director of Nursing (DON), unsure if Resident #2 had current treatment orders for open wounds but is aware that Resident #2 had abdominal wound. DON revealed expectation that picking and self harm behaviors would be care planned as well as interventions to prevent behavior. DON unaware if Resident #2 had current Psychiatric services, but stated she would need to have this in place.

F 755 SS=D — Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) — F 755

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 755		F 755		

Continued From page 156
sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility policy review the facility failed to keep an accurate narcotic count record for 1 of 1 resident reviewed for narcotic count (Resident#12). The facility reported a census of 31 residents.

Findings include:

The Minimum Data Set Assessment for Resident#12 dated 7/12/24 included diagnosis of dementia, hip fracture and depression. The MDS reflected a short- and long-term memory problems and moderately impaired daily decision-making skills.

The Care Plan for Resident#12 dated 11/6/23, directed medication as ordered.

The Medication Administration Record (MAR) for Resident#12 dated 8/2023, directed Tramadol 50 milligrams (mg) daily.

The Controlled Medication Utilization Record dated 7/24/24, revealed the count record started at 30 pills. The count decreased by 1 pill day as signed out through 8/7/24. The record failed to reflect the administration of trauma on 8/2/24 and 8/3/24 in the flow of the daily count.

The Controlled Medication Utilization Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 755	Continued From page 157	F 755		

reflected on 8/7/24 at 12:30 after Staff E, former Director of Nursing gave the daily dose, 20 pills remained. Staff E, documented on the record a late entry that revealed she failed to document and subtract the medication she administered to Resident#12 on 8/2/24 and 8/3/24 and the narcotic count then reflected 18 Tramadol remained.

The Controlled Medication Utilization Record reflected on 8/9/24, Staff Q Licensed Practical Nurse (LPN) documented on 8/5/24 and 8/6/24 She worked the day shift on the floor. At that time the Narcotic count was correct for Resident#12. The documentation from Staff E on the record reported on 8/7/24 Staff A, Registered Nurse (RN) reported the narcotic count correct. The note described on 8/9/24 the medication from this pill pack were taken from places that are inconsistent with protocol and late entries are added to the sheet altered the count. Staff E wrote she believed 2 pills were wasted or were unaccounted for.

The Controlled Medication Utilization Record reflected a second note signed by Staff A, RN that indicated on 8/7/24 the narcotic count reflected correct number at the end of the shift. Staff A, revealed Staff E didn't want to count with her.

The Controlled Medication Utilization Record reflected a note dated 8/9/24, written by an unknown staff revealed, statements, Medication records, copies of the narcotic card, sent to the Regional Vice President of Operations (RVPO) and the Administrator.

On 8/25/24 at 3:26 PM, the RVPO wrote in an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 755	Continued From page 158	F 755		

email: she filed to know of a narcotic investigation related to Resident#12.

On 8/26/24 at 4:56 PM, Staff M, former Administrator reported a narcotic medication discrepancy a few weeks ago. Staff M indicated Staff A and Staff Q reported something about narcotics and they couldn't find, it was something about Staff E and she didn't click it, something she circled on the mar and didn't sign out of signed out and didn't click. Staff M reported she talked to RVPO.

On 8/27/24 at 10:25 AM, the Administrator found pictures of Resident#12's narcotic medication cards. The photograph of the card showed 3 doses removed on the right side of the card, not in the order of numbered tabs. The written note on the bottom of the card revealed the removal order from 30 to 1.

On 8/27/24 at 12:59 PM, Staff E reported she worked 8/2/24, 8/3/24, 8/4/24 and she administered the medication but forgot to sign them out on 2 of the 3 days. She said the other nurses failed to count the narcotics correctly and she had to fix the numbers and sign them out. She stated the other nurses were out to get her.

On 08/27/24 at 1:44 PM, Staff A revealed Staff Q told her Staff E went in to the Resident#12's narcotic sheet and altered the count and removed 2 doses of the tramadol. Staff A reported she made copies of the records provided them to the Staff N, Administrator and the Administrator told her she'd take care of it.

On 8/27/24 6:15 PM, the DON said she expected the staff report any inconsistency with the narcotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 755	Continued From page 159 count, she expected the nurses count the narcotic together visualizing all the narcotics with the counts. The facility provided a policy titled Medication Administration dated 12/23, it included Narcotic Drug Handling and Documentation directed, at the beginning and end of each shift, two nurses will count all narcotics to validate accuracy of count of medication and documentation. This process will continue until either the medication is discontinued or the resident discharges. The narcotic count books should be locked in the narcotic drawer if not in use.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 758	Continued From page 160	F 758		

drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure physician orders for as needed (PRN) antipsychotic medication was limited to fourteen days and failed to ensure adequate indication for use of PRN antipsychotic medication for two of six residents reviewed for unnecessary medications (Resident #11, Resident 16) . The facility reported a census of 31 residents.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 758	Continued From page 161	F 758		

1. Review of Resident #11's Minimum Data Set (MDS) assessment dated 6/1/24 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident had a diagnosis of schizoaffective disorder, bipolar type. Per this assessment, the resident received antipsychotics on a routine basis only.

The Care Plan dated 3/5/24, revised 5/4/24, revealed, [Resident #11] uses psychotropic medications r/t (related to) Disease process Schizophrenia and Bipolar disorder.

The Physician Order dated 2/22/24 revealed, Chlorpromazine HCl Oral Tablet 50 MG (an antipsychotic medication) with directions to give 50 mg by mouth as needed for agitation related to schizoaffective disorder, bipolar type one tab PO (per oral) bid (twice a day) PRN (as needed) for agitation.

Review of the Consultation Report dated 4/24/24 for Resident #11 from the Pharmacist revealed the following per Comment Section: [Resident #11] has a PRN order for an antipsychotic without a stop date: Chlorpromazine. Recommendation: Please discontinue her PRN chlorpromazine. If this PRN antipsychotic cannot be discontinued at this time, the prescriber should directly examine the resident to determine if the antipsychotic is still needed and document the specific condition being treated prior to issuing a new PRN order. Thank you. The Physician Response section dated 5/15/24 revealed, I decline the recommendation(s) above and do not wish to implement any changes due to the reason below. Rationale: GDR (gradual dose reduction) not recommended at this time. GDR would cause

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 758	Continued From page 162	F 758		

undue patient harm. Patient continues with schizoaffective disorder, anxiety, major depressive disorder and insomnia.

Review of Resident #11's Medication Administration Record (MAR) dated May 2024 revealed the resident received PRN Chlorpromazine HCL Oral Tablet medication five times in the month, administered on the following dates: 5/10/24, 5/24/24, 5/25/24, 5/26/24, and 5/30/24.

Review of Progress Notes for Resident #11 revealed, in part, the following reasons for administration of PRN antipsychotic medication:

a. 5/24/2024 8:18 PM: Increased anxiety over owing a bill here, and being told by marketing and activities she will have to buy her own incontinence supplies if remains incon (incontinent), and wont be able to afford pop.

b. 5/26/2024 at 10:27 PM: Anxiety.

2. Review of Resident #16's MDS assessment dated 7/3/24 revealed Resident #16 had severely impaired cognitive skills for daily decision making. Per this assessment, Resident #16 took antipsychotics on a routine basis only.

The Care Plan for Resident #16 dated 5/29/24 revealed, The resident uses psychotropic medications r/t (related to) Behavior management.

Review of Resident #16's Physician Orders revealed the following medication ordered 8/12/24: Seroquel Oral Tablet 50 mg (an antipsychotic medication) with instructions to give

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 758

Continued From page 163

50 mg by mouth every 24 hours as needed for at bedtime agitation. It was noted the Physician Order page was generated for the resident on 8/27/24, which indicated PRN antipsychotic medication order in place which exceeded 14 days.

On 8/19/24 at 3:11 PM, Resident #16 observed in a recliner chair in the common area of the facility.

On 8/28/24 at 8:27 AM, the Interim Director of Nursing (DON) explained she had not been able to look at antipsychotics, and did not know if had seen a lot of PRNs actually.
The DON acknowledged she was not sure if would be effective as takes awhile to get in the system.

The Facility Policy titled Behavioral Management Standard, dated October 2023, revealed, All resident behavior has meaning. It is the standard of Behavior Management to identify the cause and meaning of behaviors that are distressing and impact negatively on the resident's quality of life. We will work diligently to minimize the utilization of psychoactive medications in our resident population. Behavior Management is for all behaviors no matters what the source or diagnosis.

F 760 SS=J

Residents are Free of Significant Med Errors
CFR(s): 483.45(f)(2)

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on interview, facility record review, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 760	Continued From page 164	F 760		

hospital record review, the facility failed to ensure an antiplatelet medication was held for Resident #127, who had a known low Red Blood Cell Count, low hemoglobin, low hematocrit, and low platelet labs. Antiplatelet medications prevent blood from clotting and can increase the risk of bleeding. Resident #127 fell from their wheelchair on 8/9/24 and struck their head on the floor. The admission orders included instructions to hold the antiplatelet medication, however, the facility administered the medication on 8/10/24 post fall without conducting any neurological, post fall assessments to assess for potential signs/symptoms of bleeding and/or identify the need to hold this medication. Resident #127 displayed a change of decreased meal intake with drooling and pocketing of food and change in ability to take oral medications. Resident #127 remained at the facility until transferred to the Hospital on 8/11/24 where they were diagnosed with an intracranial hemorrhage involving the left lateral aspect of the occipital lobe post fall. Resident #127 transferred from the Hospital to another facility where she passed away on 8/15/24 with the cause of death determined to be intracerebral hemorrhage.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 09, 2024, on August 26, 2024 at 3:15 p.m. As of the exit date, August 28, 2024, the immediacy was not removed.

The facility identified a census of 31 residents.

Findings Include:

Resident #127 admitted to the facility on 8/09/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 760	Continued From page 165	F 760		

from the Hospital. No Minimum Data Set (MDS) entry assessment or Medicare 5 day assessment completed or submitted, assessments remained in progress status. No MDS discharge assessment initiated for discharge to the hospital on 8/11/24.

The facility's Electronic Health Records (EHR) was absent for a baseline Care Plan assessment, required to be completed within 48 hours of admission.

Resident #127's medical record lacked a completed plan of care to address care needs, preferences, high-risk medications, or safety risks.

The Clinical Admission Assessment, dated 8/09/24, revealed Resident #127 had moderate cognitive impairment with symptoms of agitation and anxiety and wandered at night. The assessment revealed that Resident #127 had no nutritional concerns upon admission and had one area of skin impairment with redness noted to the coccyx. No safety care needs or functional abilities identified in the Admission Assessment.

The Hospital History and Physical (H&P), dated 8/01/24, revealed Resident #127 had presented to the Hospital with altered mental status. The H&P informed that Resident #127's Computed Tomography (CT) scan and urinalysis (UA) had both shown negative results.

A Head CT scan, without intravenous contrast, performed at the Hospital and signed by Provider on 8/01/24, revealed findings of no acute intracranial abnormality.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 760		F 760		

Continued From page 166

A Hospital note, dated 8/07/24, revealed the head CT noted no acute process; Plavix 75mg and Aspirin 81mg to be held due to family preference and low platelet count.

The Hospital Discharge Orders, dated 8/09/24, directed for the antiplatelet medication clopidogrel (Plavix) 75 milligrams (mg) to be started on 8/20/24. Hospital Discharge Orders additionally instructed for an in-person follow up visit with the Primary Care Provider within 7-14 days to re-evaluate platelet level before resuming Plavix medication.

A review of the facility's Nursing Progress Notes, revealed the following entries:
1. On 8/09/24 at 12:41 PM, Facility Nurse received report from Hospital Nurse. Resident #127 arrived to facility via private car. Nursing noted all orders and assessments completed.
2. On 8/09/24 at 2:47 PM, Resident #127stood and fell to the floor in common area. Two Certified Nursing Assistant (CNA) staff observed the fall. Nursing noted a small skin tear on back of left hand but unable to determine if fall caused the skin tear. Two staff assisted Resident #127 back into wheelchair and Nursing documented neurological checks to be performed.
3. On 8/10/24 at 12:37 AM, an as needed dose of the antipsychotic medication Olanzapine 5 milligrams (mg) given due to Resident #127 behavioral symptoms of screaming "help me, help me", "please, please", agitation, and physical aggression towards staff. Nursing noted medication had been ineffective in symptom management.
4. On 8/10/24 at 4:55 PM, Resident #127 continued to yell when awake. Nursing noted resident refused the midday meal but ate nearly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ____ B. WING ____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 760		F 760		

Continued From page 167

all of the morning meal, and took crushed medications without issue.
5. On 8/10/24 at 11:00 PM, an entry from the Nurse Practitioner (NP) indicated Resident #127 was not swallowing, even pureed foods, drooling, and pocketing food. NP noted that a tele-health visit offered, but informed that due to the inability of Resident #127 to take oral medications and a decrease in oral intake, recommendation made to send Resident #127 out to Hospital for failure to thrive and a psychiatric evaluation related to aggression.
6. On 8/11/24 at 1:45 PM, Nurse called 911 to send Resident #127 to the Emergency Room (ER) and called the Hospital to give report.
7. On 8/11/24 at 1:50 PM, Resident #127 transferred from facility via ambulance to Hospital ER for evaluation and treatment of psychiatric issues and for failure to thrive.

The Medication Administration Record (MAR), dated August 2024, revealed an order for Clopidogrel Bisulfate (Plavix) 75mg by mouth one time a day with the start date of 8/10/24, no indication of hold dates, and no end date listed. According to the MAR, Plavix 75mg had been administered to Resident #127 on 8/10/24.

The medical record lacked documentation of monitoring for side effects of administering the Plavix medication.

On 8/21/24 at 1:46 PM, Staff P, CNA, informed that on 8/09/24 around 2:00 PM, Resident #127 displayed agitated and restless behaviors, when the resident was leaning forward and backward in her wheelchair while in the common area. Staff P revealed she witnessed Resident #127 stood up from the wheelchair and fell forward, and hit the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 760		F 760		

Continued From page 168
upper left side of her forehead on the floor when she fell, and obtained a scratch on her hand.

On 8/22/24 at 12:04 PM, Staff E, former Director of Nursing (DON), reported observation of Resident #127 on the floor in the common area, down on her left side, following a fall from the wheelchair on 8/09/24. Staff E stated Resident #127 had agitated behaviors at the time of the fall and revealed that due to continued behaviors and disturbance of other residents, it was decided for Resident #127 to move to a room in the unoccupied West hallway. Staff E reported that no one said anything about Resident #127 pocketing food until 2 days later when the charge nurse sent the resident out to the hospital.

An Emergency Department note, dated 8/11/24, revealed Resident #127 arrived via ambulance from the facility with the chief complaint of failure to thrive and psychiatric evaluation related to combativeness, not eating, and insomnia. Physical examination revealed mild swelling and bruise noted to the right occipital (back of head). Hospital diagnosed Resident #127 with intracranial hemorrhage and altered mental status with plans for Resident #127 to transfer to a different facility and receive comfort cares.

A Hospital note, dated 8/11/24, revealed a Head CT scan performed due to fall and altered mental status, findings included a 2.5 centimeter (cm) focus of parenchymal hemorrhage involving the left occipital lobe.

A Death Certificate for Resident #127, listed the date of death on 8/15/24 at 7:40 AM. Immediate cause of death determined to be intracerebral hemorrhage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 760 Continued From page 169 F 760

On 8/28/24 at 8:04 AM, the current interim Director of Nursing (DON), revealed the transcription of admission orders would be the responsibility of the DON and stated that a system for a second nurse to double note orders was supposed to be in place but had not been occurring. The DON revealed an expectation of nurses to follow physician's orders and not restart a medication without a Physician order to do so. The DON stated the concern for administration of anti-platelet medication to a resident with known abnormal platelet laboratory results included bleeding, blood loss, and bruising. The DON informed that fall protocol included immediate nurse assessment of residents and completion of neurological checks if a resident hit their head, had an unwitnessed fall, or if resident was unable to verbalize if head had hit during fall. Additionally, DON expected nurses to complete post fall assessment every shift for 3 days.

The facility policy titled, Medication Administration Guidelines, dated October 2023, revealed the expectation to clarify and verify all medication orders with clinical staff from transferring hospital or facility, and the Physician. The policy defined a medication error as any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the healthcare professional or resident.

F 801 SS=F Qualified Dietary Staff
CFR(s): 483.60(a)(1)(2) F 801

§483.60(a) Staffing
The facility must employ sufficient staff with the appropriate competencies and skills sets to carry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 801	Continued From page 170 out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 801	Continued From page 171	F 801		

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and facility document review, the facility failed to have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 801	Continued From page 172 Dietary Manager with the appropriate qualifications to ensure safe practices and resident dietary needs are met. The facility reported a census of 31 residents. Findings include: On 8/19/24 at 10:15 AM, Staff T, Housekeeping Supervisor, present to complete initial kitchen tour. On 8/20/24 at 12:36 PM, during lunch meal service observation, Staff X, Cook, and Staff T, Housekeeping Supervisor, present to prepare and serve lunch to residents. No Dietary Manager present during observed meal service. Staff T reported facility had a Dietary Manager, who was signed up for Certified Dietary Manager (CDM) classes, but not currently certified. On 8/26/24 at 4:47 PM, Staff N, former Administrator, revealed that Dietary Manager had recently been hired, however, she stated employment "fell through". Staff N reported that the Dietary Manager served residents an evening meal of green beans, mashed potatoes, saltine crackers, and chocolate muffin on 8/17/24, Staff N stated she had been notified of meal and purchased residents pizza on the evening of 8/17/24. Staff N revealed that the Dietary Manager then did not show up for work on 8/18/24 or 8/19/24 and had employment terminated on 8/19/24. Facility unable to provide documentation of CDM certificate or similar training for Dietary Manager or Dietary staff.	F 801		
F 835 SS=L	Administration	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835		F 835		

Continued From page 173
CFR(s): 483.70

§483.70 Administration.
A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident interview, staff interview, and facility record review, the facility failed to effectively manage the facility to ensure resources available to meet staffing and resident needs. As of 8/26/24, the facility has 9 unremoved Immediate Jeopardy (IJ)s pertaining to the following regulations: F684 assessment / intervention and F697 pain management IJs identified on 8/21/24; F600 freedom from abuse, F609 reporting abuse allegations, and F610 separation of potential abusers and comprehensive abuse investigation IJs identified on 8/22/24; and F725 insufficient staffing, F726 insufficient competent staff IJs identified on 8/25/24. F760 significant medication error and F835 administration identified on 8/26/24. An additional unremoved IJ identified for F741 sufficient/competent staff-behavioral health needs identified on 8/28/24, bringing the total number of unremoved IJ level deficiencies to 10. This deficient practice placed 31 of 31 residents who resided at the facility at risk for serious injury, serious harm, serious impairment or death. The facility reported a census of 31 residents.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 19, 2024, on August 26th at 9:30 a.m. As of the exit date, August 28, 2024, the immediacy was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835	Continued From page 174	F 835		

not removed.

Additionally, a Life Safety Code survey inspection conducted separately, found 2 IJs under Ktag 222 and Ktag 343 and the facility notified of both on August 29, 2024.

Findings include:

During the facility's recertification survey and investigation of facility reported incidents and complaints, conducted 8/19/24 through 8/28/24, 10 Immediate Jeopardy (IJ) level deficiencies were identified at the following regulations: F600, F609, F610, F684, F697, F725, F76, F741, F760, and F835.

Per review of the dia-hfd.iowa.gov website, a complaint investigation conducted 1/31/24 through 2/20/24 had previously identified the following deficiencies that were also noted on the current survey:

a. A harm level deficient practice at regulation F684 assessment/intervention previously identified on survey conducted 1/31/24 to 2/20/24.

b. A deficient practice identified at a pattern level at regulation F741 sufficient staff-behavioral health needs previously identified on survey conducted 1/31/24 to 2/20/24.

c. A deficient practice identified at regulation F760 significant medication error previously identified on survey conducted 1/31/24 to 2/20/24.

d. A widespread deficient practice at regulation F835 administration previously identified on survey conducted 1/31/24 to 2/20/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835	Continued From page 175	F 835		

Review of the revisit survey which was completed on 2/20/24 revealed the following deficient practice was again identified:

a. A deficient practice was again identified at regulation F684 assessment/intervention. The facility alleged to be in compliance with the deficient practice on 4/5/24.

On 8/21/24 at 11:09 a.m., during an interview with Staff B, Certified Nursing Assistant (CNA) queried if she normally worked on the CCDI (Chronic Confusion or Dementing Illness) area of the facility. Staff B responded she did, had always just been her, and had been brought up to corporate. Per Staff B, the response provided was didn't want to hear another word about state compliance.

On 8/22/24 at 9:09 a.m., during an interview with Staff L, former Regional Nurse Consultant (RNC), Staff L explained didn't really know who [residents] would be coming in, you get these residents and just need to deal with them. Staff L explained the admissions were pushed by the corporation to increase the census. On 8/22/24 at 9:38 a.m., Staff L explained the Director of Business Development would be in contact with the hospital and everything and would decide if the resident was going to be admitted. When agreed to take the resident, the facility would be called and say getting resident, and sometimes it varied with the type of notification. The facility would get the resident, and then would go through the admission process bringing them (resident) in, doing assessments, getting orders, stuff like that. Per Staff L, the DON responsible for directing the admit, making sure orders put in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835		F 835		

Continued From page 176
computer, getting the nurses to also assist with the admission. Per Staff L, for the facility the DON ended up doing most of the admission if not all.

On 8/22/24 at 9:42 a.m., when queried about non-clinical staff doing clinical duties, Staff L explained there had been multiple conversations about staffing of the facility. Staff L further explained she had heard non-certified back [CCDI unit] there doing cares shouldn't have been doing, and she would tell the DON and the Administrator, and told DON/Administrator only certified assisting with residents. Per Staff L, have had conversations with the corporate office talking about what certified versus non-certified can do back there. Staff L further explained unless in case of emergency, any time have an employee touching a resident needs to be certified.

On 8/25/24 at 2:25 p.m., during an interview with Staff Q, Licensed Practical Nurse (LPN), Staff Q explained the following pertaining to being able to fax: Normally if she needed a medication out of the e-kit (emergency kit), she would request pharmacy to fax, and would be faxed back a confirmation code so could take it out. Staff Q explained she could not do that, or like for a [specific office name], knew if faxed would get that quicker. When queried what management had said about the fax, Staff Q responded with the following: She heard the bill was too high, the physical line had been cut, IT (Information Technology personnel) couldn't figure out how to get it to work, and heard the Director of Nursing wanted to manage what was said to the doctor.

When queried if the lack of an operational fax machine prevented communication from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835		F 835		

Continued From page 177
occurring, Staff Q responded, heck yeah, lots. Per Staff Q, when medications were not in, the pharmacy would normally fax, and Staff Q would have no idea and would not get any of that. Staff Q explained if got lab results back she would not get any of that. The same was described with hospital faxes. When queried how got labs, Staff Q responded, no idea, nursing is rarely privy to anything medical.

On 8/26/24 at 9:02 a.m., the Regional Vice President of Operations contacted the State Agency and reported the staffing agency lined up called off and did not show up to work. The Regional Vice President voiced she had no idea what else to do but to start evacuating residents and it would not be a popular decision with her corporation representatives above her but she felt she had no choice as they could not meet resident needs with the current staffing levels.

On 8/26/24 at 9:48 a.m., the Regional Vice President of Operations explained 13 residents would be transferred out to sister facilities, the only residents left would be in the closed unit [CCDI unit], and could staff for that.

On 8/26/24 at 4:56 p.m., during an interview with Staff N, Former Administrator, Staff N explained the following: The facility did not have a working fax since before she stepped foot in the building. When queried if not having a fax machine presented issues, Staff N responded, I think they were dependent on it. Staff N explained being told in the past that it was not ideal to fax physician orders because could be delayed or lost in translation. When queried about it causing problems, Staff N responded she was sure it did, wasn't because hadn't tried to get it fixed. Per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835	Continued From page 178	F 835		

Staff N, it was a constant fight forever.

Per Staff N, regarding PPD (per patient day) and staffing issues, there were months and months of emails begging for help. Per Staff N, she was told by [higher level corporate staff member] that agency would not be paid, and would fix using agency because would not pay them. Per Staff N, could not use [agency name redacted] because would not pay them. Staff N explained the following about CNAs in the building: Per Staff N, was told with 24 residents it would be 8 CNAs, 3 days, 3 second shift, 2 overnights. Staff N explained then moved to only 6, 2 days, 3 for nights, and 1 overnight. Per Staff N, she said not doing 1 staff. Per Staff N, response provided to her was could go over what-ifs all day long. Staff N further explained she was told could have 2 for overnights, but would have to take a staff member from days. When queried how would then cover, Staff N explained leadership would have to take shifts back there.

Staff N explained one certified person in the back [CCDI unit] and one non-certified could be anybody. Staff N explained the facility was like having two separate facilities, and needed common staff because need to know resident routines. Per Staff N, a call occurred with [management staff], was communicated that have had enough of your PPD (per patient day), would not be signing off on PPD until understood exactly what the facility had been cited for. Per Staff N, was told if increased census would get more staff. Per Staff N, access to recruiting software had been taken away from Staff N, former Administrator as it wasn't their job to recruit CNAs. Staff N explained they had been without a maintenance man since mid-June, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 835	Continued From page 179	F 835		

there were 23 applicants for maintenance.

Staff N also explained the following about the resident admission process: There was a central intake where things were faxed to, clarified as being located offsite. That is who would say yes or no to admit or not. Per Staff N, it didn't matter what they thought and would be told the facility had an admission coming this afternoon. Per Staff N, the previous Director of Nursing (DON) would know the admission was coming and it would be announced in email. When queried if that gave enough time to get needed supplies, Staff N responded not always, no. Staff N provided the following examples: for a gentleman last week didn't realize the resident needed a bariatric wheelchair, for a resident Staff N believed had to get wound vac stuff, not sure if needed to get that or get from the hospital, and had someone come in a few weeks back that needed formula, which was picked up by [name redacted] from the hospital.

When queried about completion of skilled assessments, Staff N acknowledged there had been some confusion whether individuals skilled or not.

When queried about scheduling, Staff N explained that was an issue because when [another former Director of Nursing] was present that former DON had the master schedule. When [former DON, Staff E] took over, Staff E was a fan of self scheduling. Staff N explained it worked for a little while and then didn't. Staff N explained the following process had been utilized: Everyone would be handed a schedule and asked which days in August wanted to work. There were open shifts to fill, which was why the facility ended up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835		F 835		

Continued From page 180

with [scheduling program name redacted]. Staff N explained CNA staff were self scheduling as well. Per Staff N, there had been a lot of conversation, and work to implement a template schedule so would take the confusion away, and [Staff E] had people scheduled through the end of August so they were doing pretty well. Per Staff N, when the census picked up by then, did not have anyone hired, and hired and then don't call them. Staff N explained there was a specific individual, CNA, who did the recruiting. Staff N explained she was told by management that did not have this problem in other building.

When queried if acuity taken into consideration with staffing, Staff N acknowledged she kept speaking about this. Staff N posed how recommendations could be implemented when the Interim DON worked the floor.

On 8/27/24 at 3:31 p.m., when asked if the Corporate Chief Operating Officer had told the facility staff they could not have additional staff until their census went up as the PPD was too high, the COO responded that yes he did question the facility about their PPD numbers (per patient Day which is a calculation used in nursing homes to determine the number of nursing hours allotted per day per resident and is a key performance indicator that helps skilled nursing facilities monitor their financial health). The COO stated it was a prudent thing to do if he saw the PPD number too high. When asked what staff reported to him on why they needed additional staff, the COO responded it was mostly because of repeated staff call ins. The COO denied telling the facility they could not use agency staff but they could not get any agency staff to work and they tried to get additional staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835	Continued From page 181 for them. The COO acknowledged that per previous routine update calls with the State Agency, they had reported owing a large amount of money to a temporary staffing agency. The COO stated he was actively working at that moment on another contract with a different staffing agency and they had access to others. On 8/27/24 at approximately 5:30 p.m., the COO and On 8/27/24 at 3:31 p.m., when asked if the COO had told the facility staff they could not have additional staff until their census went up as the PPD was too high, the COO responded that yes he did question the facility about their PPD numbers (per patient Day which is a calculation used in nursing homes to determine the number of nursing hours allotted per day per resident and is a key performance indicator that helps skilled nursing facilities monitor their financial health). The COO stated it was a prudent thing to do if he saw the PPD number too high. When asked what staff reported to him on why they needed additional staff, the COO responded it was mostly because of repeated staff call ins. The COO denied telling the facility they could not use agency staff but they could not get any agency staff to work and they tried to get additional staff for them. The COO acknowledged that per previous routine update calls with the State Agency, they had reported owing a large amount of money to a temporary staffing agency. The COO stated he was actively working at that moment on another contract with a different staffing agency and they had access to others. he Administrator notified the State Agency had determined the facility needed to enact their emergency evacuation plan as another immediate jeopardy situation had been identified for life safety code violation in relation to the fire	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835	Continued From page 182	F 835		

panel not communicating to the monitoring company and therefore Emergency Medical Services would not be able to be notified in the event of a fire or emergency.

On 8/28/24 at 8:46 a.m., during an interview with the current Interim Director of Nursing (DON), when queried about staff working in excess of the amount of hours in their shift, the DON explained CNAs and nurses she thought both had worked over their 12 or 8 [hours], she thought related to both staff not showing up and needing to stay, and explained she had done the same. When queried about herself (DON) working long hours/how long, the DON explained she had been on for 34 hours, did have a couple 2 or 3 hour breaks, this was right before State Agency got to the facility, and nobody would come in/answer the phone. Per the DON, corporate was calling and texting people trying to get other facilities to come. The DON explained it was an ongoing battle and was worse and worse.

On 8/28/24 at 9:02 a.m., when queried if there was a working fax machine, the Interim DON responded no. The DON did not know exactly how long it had been out, and explained it had been out since she got to the facility. When queried if it was the machine or phone line, the DON responded told both, so no one knows what it is. When queried if the bosses knew, the DON explained Staff N, and said the current Administrator eventually found out. When queried if that presented issues, the DON responded, yes. Per the Interim DON, they were about to email and text the doctor, and were not able to fax anything to the office. When queried if nurses not in a management role would have an email address, the DON responded she did not know if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835		F 835		

Continued From page 183
they had an email. The DON explained had a phone number and text. It was described that the doctor would text initials and this is an order, or come to the DON and the DON would email him. The DON explained it was very inconvenient and were making it work.

The DON did not know if staff had texted. Per the DON, usually the doctor would call, or the DON would text him to call. When queried how communication would occur with pharmacy, the DON explained via phone or order stuff on the computer. When queried if there would be need for a nurse to fax stuff to the pharmacy, the DON explained it would be very convenient to get orders in quicker. When queried if it caused a delay not having a fax to get orders in, the DON responded potentially.

When queried about scheduling, the DON explained on [scheduling program] everyone had individual schedules. The DON explained there was a master schedule and she did not have access to it. Per the DON, Staff N had wanted to do it. The DON further explained she did not see a master schedule that the staff could see until she got one from [Vice President (VP) of Operations]. The DON acknowledged staff had said they did not know who was working, and wanted to see who was working with them in advance. The DON explained she asked [VP of Operations] to print one, and that is when she was given access.

During an interview on 8/22/24 at 12:42 p.m., Staff A, RN stated she had received a phone call from The DON at 12:30 p.m. stated she was informed that the nurses need to do pain assessments and that there was a discrepancy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 835	Continued From page 184	F 835		

on orders so the nurses have to make sure everything should be on the check off list. Staff A stated that was the extent of the response to the Immediate Jeopardy (IJ) for the lack of skilled assessments and for the lack of care for the resident with the abdominal drains.
During an interview on 8/26/24 at 5:25 a.m. Staff R, LPN, stated she was "exhausted" and did not have a working fax machine to send the daily sheets to the corporate. Staff R stated the Agency CNA that was scheduled for the day shift called in at 3 a.m., she had notified the Director of Nursing (DON) by a text that she would not have a day shift CNA. Staff R stated she felt like she had Post Traumatic Stress Disorder (PTSD) due to the stress, anxiety and worry for her nurse licensure. Staff R was tearful and stated that there were no falls during the night but was unable to complete the skilled assessments for the 5 skilled residents. Staff R stated she worked multiple days and did not remember the last time she completed the skilled assessments, did not have time to follow up on falls and did not have a second person to assist the residents who were a maximum assist of 2 staff. Staff R stated she had brought Resident #16 out to the living room area during the night as he was a fall risk and needed monitoring. Staff R stated the staff called 911 for help on 8/24/24 due to no staff on evening shift.

During an interview on 8/28/24 at 8:40 a.m. Staff D, Social Services/Activity Director stated on 8/11/24 around 2 p.m. there was no visible staff in the front portion of the building with 17 residents and Resident #77's call light was activated. Staff D stated she took Staff K, CNA who entered the building with her to assist Resident #77 to the bathroom. Staff D stated Resident #77 was too weak and slid to the floor during transfer back to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 835	Continued From page 185 bed. Staff D stated it was not "graceful" but she "scooped" Resident #77's arm and returned her to bed. Staff D stated she would never hurt anyone, but she was not a CNA. Staff D stated Staff N, former Administrator, "forced" management staff to work in the Dementia unit to get residents up, shower them, dress and clean them. Staff D stated "I did what I was told to do, not by my own free will". Staff D stated Staff N worked in the Dementia unit on multiple days and gave care to the residents. Staff D stated the facility did not have enough staff to care for the residents.	F 835		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 865	Continued From page 186	F 865		

promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 865	Continued From page 187	F 865		

(or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 865	Continued From page 188 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on previous CMS-2567 review, staff interview, and facility policy review the facility failed to ensure a comprehensive, effective quality assurance and performance improvement program for all 31 of 31 residents who resided in the facility. Findings include: Per review of the dia-hfd.iowa.gov website, the following deficiencies had been previously identified per a complaint investigation conducted 1/31/24 to 2/20/24. The following deficiencies were later cited at the IJ level during the facility's recertification survey, conducted 8/19/24 to 8/28/24. a. A harm level deficient practice at regulation F684 assessment/intervention previously identified on survey conducted 1/31/24 to 2/20/24. b. A deficient practice identified at a pattern level at regulation F741 sufficient staff-behavioral health needs previously identified on survey conducted 1/31/24 to 2/20/24. c. A deficient practice identified at regulation F760 significant medication error previously identified on survey conducted 1/31/24 to 2/20/24. d. A widespread deficient practice at regulation F835 administration previously identified on survey conducted 1/31/24 to 2/20/24. Review of the revisit survey findings from a survey conducted 3/25/24 to 4/1/24, to revisit the survey completed on 2/20/24, revealed a deficient practice again identified at regulation F684 assessment/intervention. The facility alleged to	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 865		F 865		

Continued From page 189
be in compliance with the deficient practice on 4/5/24.

During the course of the facility's recertification survey with investigation of complaints and facility reported incidents conducted 8/19/24 through 8/28/24, ten Health immediate jeopardy (IJ) level deficient practices were identified at the facility under six different federal regulatory groups. IJ level deficient practices were identified with the following federal regulatory groups:

a. 483.12 Freedom from Abuse, Neglect, and Exploitation: F600 freedom from abuse, F609 reporting of alleged violations, F610 investigate/prevent/correct alleged violation
b. 483.24 Quality of Care: F684 Quality of Care and F697 Pain Management
c. 483.35 Nursing Services: F725 Sufficient Nursing Staff and F726 Competent Nursing Staff
d. 483.40 Behavioral Health: F741 Sufficient/Competent Staff-Behav Health Needs
e. 483.45 Pharmacy Services: F760 Residents are Free of Significant Med Errors
f. 483.70 Administration: F835 Administration

Continued review of deficient practices previously identified during the facility's complaint survey conducted 1/31/24 to 2/20/24 deficiencies were again identified at a non-harm/IJ level with the following:

Repeat violations again identified with the previously identified regulatory group:

a.483.24 Quality of Care: F689 Free From Accidents Hazards/Supervision/Devices

Repeat violations again identified with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 865

Continued From page 190

following additional federal regulatory groups:

a. 483.21 Comprehensive Resident Centered Care Plan: F657 Care Plan Timing and Revision and F658 Services Provided Meet Professional Standards
b. 483.24 Quality of Life: F678 Cardio-Pulmonary Resuscitation
c. 483.80 Infection Control: F880 Infection Prevention and Control

The Facility Policy titled Quality Assurance Performance Improvement (QAPI) Plan/2024 revealed the following per the Mission Section: The Quality Assurance Performance Improvement program mission is to maximize the quality of resident care and facility services through a continual and proactive analysis of facility practices. The mission is to be accomplished through a systematic and interdisciplinary study of facility resources and data. The Feedback, Data and Monitoring Section revealed, in part, The QAPI Committee will determine what data to monitor but will at a minimum include:
a. Survey Results.

On 8/28/24 at 10:35 AM, the Administrator confirmed the concerns related to the effectiveness if the QA programs with the Immediate Jeopardy and system failures identified by the survey team.

F 880 SS=F

Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 880	Continued From page 191	F 880		

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 §483.71 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 involved, and
(B) A requirement that the isolation should be the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 880	Continued From page 192	F 880		

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, staff interview and facility policy review the facility failed to track infections, failed to isolate a resident with symptomatic Coronavirus disease (COVID-19), failed to complete hand hygiene and maintain Infection Control practices for 2 out of 2 residents reviewed, failed to have the Medical Director sign the reviewed Infection Control (IC) policies and procedures. The facility reported a census of 31 residents.

Findings include:

1. The Infection Control information in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(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 880	Continued From page 193	F 880		

Director of Nursing (DON)'s office lack and documentation of infection tracking from 1/2024 through 7/2024.

2. The Infection Control information in the DON's office lack an annual review of the facility Infection Control policies and procedures by the Medical Director.

On 8/26/24 at 3:40 PM, the Interim DON reported she started in this building 2 weeks ago. The DON revealed she failed to find an infection control tracking book.

On 8/27/24 at 1:40 PM, the DON reviewed the facility IC book and she failed to find documentation the Medical Director signed that the IC Policies and Procedures were reviewed in the past year.

On 8/27/24 at 6:15 PM, the DON reported she expected the Infection tracking completed each month with all the infections. She expected the Medical Director to review the Policies & Procedures each year as required. She said a resident with positive COVID needed to stay in a room by herself and the other exposed resident needed a room alone.

The facility provided a policy titled Infection Control Manual dated 2023, the first page included blank signature lines for the Administrator, DON, and the Medical Director.

The facility strives to prevent transmission of infections and communicable diseases, development of nosocomial infection, and effectively treat and manage nosocomial and community acquired infections. The goal of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING ___ B. WING ___	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	**901 STATE STREET DONNELLSON, IA 52625**

(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 880		F 880		

Continued From page 194
program is to identify and reduce the risks of acquiring and transmitting infections among residents, employees, volunteers, and visitors. The program includes a system to monitor and investigate infection trends. The program is developed based on nationally recognized organizational standards and procedures.

A coordinated process is established to reduce the risks of nosocomial infect ions in residents and employees. The infection prevention and control process is directed at lowering risk, and improving trends and rates of epidemiologically significant infections.

2. The Medical Diagnosis document for Resident #78 revealed a diagnosis of paraplegia, urinary tract infections and chronic kidney disease.

The Care Plan for Resident #78 failed to address the catheter or provide direction for staff regarding monitoring and care.

The Physician Orders for Resident #78 dated 8/14/24 revealed orders to: change catheter every month on the 9th, catheter size 16 French.

During an observation on 8/20/24 at 1:49 p.m. Staff J, Certified Nursing Assistant (CNA) failed to perform hand hygiene before applying his personal protective equipment (PPE) gloves and gown, failed to place a barrier between the floor and the graduate to prior to emptying the catheter drainage bag, and failed to perform hand hygiene after the removal of PPE.