STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165344	A. Building B. Wing	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review and staff interview, the facility failed to assure each resident received treatment with respect and dignity in addition to caring for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 2 of 4 residents reviewed (Resident #4 and #8). The facility reported a census of 24 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #4 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident demonstrated independence with toilet use and supervision with personal hygiene. The resident had frequent incontinence of urine. The resident's diagnoses included anxiety and depression. A Resident Grievance/Concern/Complaint Report dated 10/18/22 documented the previous Activity Director/Social Services designee received the report. Resident #4 complained that the Staff J Certified Nursing Assistant (CNA) felt his pants in the front dining room in front of other residents. The investigation report documented after investigating and discussing with staff and residents, Staff J would be written up for her behavior. Staff J received a write up on 11/7/22 regarding the investigation, and reeducated about resident rights and dignity. On 12/1/22 at 8:33 a.m. the resident remembered when they were having a magic show. He planned to attend. In the dining room prior to the show a CNA was being a bitch and touched him in the front of his pants, and he was mad about that. If he needed to change he would tell them. He said no one else ever did that. That should never have happened. On 12/1/22 at 8:47 a.m. Staff K Social Services Designee said when the resident reported the incident of Staff J touching him in the front, he said she clamped her hand around the genital area to see if he was wet, in the dining room, with other residents around. On 12/1/22 at 10:22 a.m. the Administrator stated she did not talk to the resident about the grievance regarding the staff member touching him in the front, with other residents present. It was a delicate subject. She asked the staff/residents about the 2nd complaint on the grievance and felt she covered it all on the staff members' written warning. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #8 had long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with toilet use and personal hygiene. The resident's diagnoses included non-Alzheimer's dementia. On 11/28/22 at 12:28 p.m. Staff B CNA and Staff I CNA brought the resident to her room for care. Staff applied a gait belt and transferred the resident with 2 assist to bed. Staff tried to pull the privacy curtain around but it was not long enough to cover the area, so they left it to keep the area of the room door covered. The windows were not covered facing out to the front of the building while staff pulled the residents pants down, changed her incontinent pad, and cleansed her perineal area. On 12/8/22 at 11:47 a.m. the Director of Nursing (DON) stated she expected staff would assure a resident would not be exposed during personal care, including from windows in the room. The Resident's Rights section of the Activity Recreation Standards dated October 2018 included: Each resident's right to personal privacy (accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups) and confidentiality shall be ensured. Each resident shall receive care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observations, clinical record reviews, and staff interviews, the facility failed to assure a treatment started in a timely manner, supplies were ordered to assure no lapse in treatment, and the facility failed to define who would administer the cream for 1 of 2 residents reviewed (Resident #9). The facility reported a census of 24 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #9 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with activities of daily living including personal hygiene. The resident's diagnoses included cerebral palsy. The current Care Plan with a goal target date of 12/14/22 identified the resident had a risk for skin breakdown related to impaired mobility. The interventions included treatments as ordered. A clinic visit note dated 10/21/22 documented that the resident presented for thickened, elongated, and discolored toenails. The resident reported pain wearing shoes with her nails as long as they were with left heel pain. The diagnoses included dermatophytosis of the nail, pressure injury of left heel, stage 1, and xerosis cutis (abnormally dry skin). The provider explained to the resident the importance of periodic foot evaluations to minimize complications from diabetes, diabetic neuropathy, and peripheral vascular disease (PVD). She recommended primary foot care periodically to help reduce the potential complications due to dystrophic (deformed, thickened or discolored nails) or hypertrophic (thickened nails without structural deformity) toenails. The provider debrided (removed damaged or foreign tissue) the toenails bilaterally in an attempt to reduce length and thickness. She noted a callus forming on the heel. The resident reported asking the staff several times to put her foot on a pillow so her heels did not rub. She recommended using urea 20% (cream used to treat calluses) to her calluses and heels two times a day for 10 weeks for her nails and for 5 weeks to recheck heel pressure area. The Progress Notes dated 10/21/22 at 2:42 p.m. documented that the resident returned back to facility from the doctor's appointment with order to keep her heels off the bed at all times, apply urea 20% lotion to calluses on her feet and her heels twice daily for 10 weeks. Not to put between toes. A return check of the heel ulcer left foot in 5 weeks, scheduled for 11/17/22. The Progress Notes dated 10/31/22 at 1:15 p.m. documented the resident reported to staff she was upset about not having cream ordered by podiatry for feet. The writer went in to discuss the resident's concerns and let the resident know the pharmacy had not sent medication and they were working to get it resolved and get the cream delivered as soon as possible (ASAP). The Medication Administration Record (MAR) for October of 2022 included Urea Cream 20 %, applied to calluses, heels, and feet topically two times a day for xerosis and mycotic nails for 10 weeks with a start date of 10/21/22. The MAR showed checks 9 times between 10/21/22 and 10/31/22 indicating the resident had the cream applied (when the cream had not been received). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR for November 2022 documented the cream administered 5 times between 11/1-5/22 (before received). The MAR documented the order discontinued on 11/6/22. The MAR documented the order to apply urea cream to calluses, heels, and feet topically every day and night shift for xerosis and mycotic (a fungal infection that affects your toenails or fingernails) nails for 10 weeks until finished with a start date of 11/6/22. A clinic visit note dated 11/18/22 documented the resident presented with a history of cerebral palsy, and the beginning of a pressure spot to her heel. The resident did mention she had to wait until 11/7/22 to get the urea 20% and had to remind the nurses about it. The heels look much better after applying the lotion and keeping them elevated off the bed. On 11/28/22 at 12:13 p.m. the resident stated she went to the podiatrist and she ordered some cream for her feet and she didn't get it until [DATE]th. In addition she ran out Friday (11/25/22) and did not have any since then. (The MAR for November showed staff continued to place a check indicating the cream was applied). On 11/29/22 at 10:31 a.m. a pharmacy representative stated they received the order for the resident's urea cream, but they had to get approval from the facility to send it, because it was an over the counter medication and they had their own provider for stock medications. They did not receive approval from the facility so they did not send the cream. On 11/29/22 at 4:49 p.m. Staff L, Licensed Practical Nurse (LPN), stated she was not there when the resident went to the podiatrist. She was told in the report the ointment had been ordered from the pharmacy. Then they discovered the pharmacy could not send the medication, so it did not get started timely. On 11/30/22 at 9:20 a.m. the resident stated she still did not have the cream for her feet. The Director of Nursing (DON) told her Monday she had ordered it, when she ran out on Friday. She questioned why they did not order it before it ran out. Staff B, Certified Nursing Assistant (CNA), removed the resident's left shoe and sock. The underside of the resident's left foot appeared dark red, and up the back of the left heel. The skin appeared scaly and peeling. The resident stated her heel hurt, and said it felt better when they put the cream on. She said they kept it in her room and the CNA's put it on. Staff B stated they (the CNA's) put it on the resident's feet. She then removed the resident's right shoe and sock and the foot and heel looked similar to the left. On 11/30/22 at 11:25 a.m. the DON stated their supplier did not have the formulary for the cream, so it was delayed, and they could not get it from another source (per corporation policy). She said she notified the podiatrist they did not have the cream and would start the cream when it arrived (the DON started on 10/31/22, 10 days after the cream was ordered). The progress notes lacked documentation of the notification. On 11/30/22 at 12:01 p.m. the DON stated the cream was not kept in the resident's room, the nurses applied it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/1/22 at 10:13 a.m. the empty container of urea 20% cream sat on top of the resident's night stand. On 12/1/22 at 5:19 p.m. Staff L stated the urea cream was an over the counter cream kept in the resident's room and the CNA's applied it.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on clinical record review and staff interviews the facility failed to develop and implement effective discharge planning for 1 of 2 residents reviewed (Resident #12). The facility reported a census of 24 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #12 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required supervision in ambulation in her room and the hall and limited assistance with dressing, toilet use, and personal hygiene. The resident had frequent incontinence of bowel and bladder. The resident's diagnoses included non-Alzheimer dementia. The Care Plan with a target date of 12/5/22 identified the focus of advance directive. The care plan had a goal identified that the resident/responsible party (RP) had determined that resident will remain at the facility for long term care and did not wish to seek community placement at the time. They would readdress community placement with the resident/responsible parties only when required (on comprehensive assessments) per resident/RP request. A Care Plan Conference Sheet dated 6/16/22 documented that the family was looking at facilities with a dementia unit. On 11/29/22 at 8:33 a.m. the resident's family member stated they took the resident to the doctor on 10/25/22. When they returned to the facility they tried to inform the MDS Coordinator about the plans for the resident to move to another facility the following week, so things would be ready. The MDS Coordinator directed them to Staff G, Certified Medication Aide (CMA), at the desk. She took down the information and numbers. On 10/27/22 another family member called the business office and they said they were aware. On 10/31/22 the family member received a call from the Director of Nursing (DON), and she said they would get a transfer order, and promised everything would be ready. They arrived before 9 a.m. on 11/1/22 and nothing was ready. They had to take wet clothes and dirty clothes with them. On 12/5/22 at 2:15 p.m. the MDS Coordinator stated she remembered something about the resident's family when bringing her back to the facility on [DATE] but could not remember exactly what it was about. On 12/1/22 at 12:55 p.m. Staff G, Certified Medication Aide (CMA), stated the family tried to get the resident out of the facility for a while. The family took her out about a week before the transfer. When they returned one of the family members notified her the resident would transfer to another facility the following Tuesday (11/1/22). Staff G wrote everything down and put the note on the Administrator's door. She didn't know what happened after that. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/22 at 2:02 p.m. the DON stated she had been at the facility one day when the resident was discharged . She started the day before. The family notified the facility of the discharge on 10/31/22, and transferring on 11/1/22. They were working on washing her clothes and they just needed to dry, but they wanted them bagged to take with them. The DON stated she even offered to bring them after they were dried to the other facility and they declined. The DON verified there was no documentation about the resident's discharge. On 12/1/22 at 3:40 p.m. the DON stated they should start preparing for a discharge as soon as they were aware of it.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42132 Based on clinical record reviews, facility policy review, and staff interviews the facility failed to complete a recapitulation of stay (a final summary of the resident's status) for 2 of 2 residents reviewed (Residents #12 and #13) discharged from the facility. The facility reported a census of 24 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #12, dated 12/1/22, identified a planned discharge date of [DATE]. The MDS identified a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS documented diagnoses of anxiety, depression and bipolar. The Progress Notes for Resident #12 revealed: a. On 11/16/22 at 4:20 PM, a health status note (HSN) revealed the resident had a telehealth visit to the ARNP (Advanced Registered Nurse Practitioner) and an order was received to discharge the resident to another facility on 11/17/22. b. On 11/17/22 at 8:00 AM, HSN indicated the resident was discharged from the facility and transported to the new facility via the nursing home van. The resident's medications were returned to the pharmacy and the resident's personal belongings were sent with the resident. c. On 11/17/22 at 10:13 AM, HSN revealed a report had been called to the nurse at the receiving facility and the resident's MARs and TARs (Medication and Treatment Administration Record) were faxed to the facility. The clinical record lacked documentation of Resident #12's recapitulation of stay, or the summary of the resident status upon discharge from the facility on 11/17/22. The facility document titled Transfer/Discharge Documentation Recommendations dated February 2015, stated to complete the following recommended documentation for a planned discharge: 1. Physician order 2. Interdisciplinary Discharge Summary 3. Discharge Information 4. Resident/Family education 5. Inventory list 6. Nursing Progress Note (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/22 at 8:59 AM the Director of Nursing (DON) stated she did not know what a Recapitulation of Stay was and had never heard of it before. On 11/30/22 at 11:00 AM during a review of the facility document titled Transfer/Discharge Documentation with the DON, she confirmed an Interdisciplinary Discharge Summary was part of the documentation for a planned discharge. The DON stated she had been informed the Interdisciplinary Discharge Summary would be located in the resident's electronic health record (EHR), however, unable to locate for Resident #12. On 12/1/22 at 8:23 AM the DON stated she went back in Resident #12's EHR and completed a Discharge Recapitulation. During the review of the facility document titled Transfer/Discharge Documentation and the DON stated the Interdisciplinary Discharge Summary was only an entry in the resident's progress notes regarding the resident discharge. The DON stated she had never completed a recapitulation, a summary of a resident's stay, upon discharge from the facility or any facility that she had worked at previously. The DON stated she worked with the Administrator on 11/30/22 and developed the Discharge Summary assessment to be utilized going forward. 26527 2. According to the MDS assessment dated [DATE] Resident #12 scored 4 on the BIMS indicating severe cognitive impairment. The resident required supervision with ambulation in her room and the hall, and limited assistance with dressing, toilet use, and personal hygiene. The resident had frequent incontinence of bowel and bladder. The resident's diagnoses included non-Alzheimer dementia. The Progress Notes dated 10/31/22 at 3:57 p.m. documented the provider saw the resident via telehealth, and was okay to discharge on 11/1/22 to another facility. The Progress Notes dated 11/2/2022 at 2:57 a.m. documented the pharmacy notified of the resident's discharge. The Progress Notes up to 11/29/22 at 6:01 p.m. lacked documentation of any details of the resident's discharge. The resident's Clinical Assessments page reviewed 11/30/22 at 11:19 a.m. lacked a Discharge Recapitulation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observations, clinical record reviews, staff, and resident interviews, the facility failed to assure residents were assisted with oral care for 1 resident (Resident #7) and received baths as planned for 4 of 4 residents reviewed (Resident #3, #4, #5, and #8). The facility reported a census of 24 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #7 had no memory problem and was independent with cognitive skills for daily decision making. The resident required extensive assistance with personal hygiene. The resident's diagnoses included spinal stenosis. On 11/28/22 at 11:08 a.m. the resident said they often don't get them in until the afternoon. She said they don't always have things set up so she can brush her teeth. On 11/30/22 at 9:10 a.m. the resident stated they did not offer her oral care, and her toothbrush appeared dry. On 12/1/22 at 9:47 a.m. the resident said they did not offer her oral care this morning. She said she got tired of asking for it and being told they would be back and never doing it. She is unable to get to the bathroom to get her toothbrush. Her toothbrush was dry. The Resident Hygiene policy dated August 2021 identified it was the standard of the facility that every resident would receive oral care at least twice daily, and as needed. Each resident will be encouraged to complete their oral care, as they were able. 2) According to the MDS assessment dated [DATE] Resident #3 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with bathing. The resident's diagnoses included chronic obstructive pulmonary disease (COPD). The Bathing record showed the resident's bath on 11/15/22 as not applicable, and no bath between 11/11 and 11/18/22. The bath on 12/2/22 documented the resident as unavailable, with no bath between 11/29 and 12/6/22. 3) According to the MDS assessment dated [DATE] Resident #4 scored 12 on the BIMS indicating moderate cognitive impairment. The resident required extensive assistance with bathing, and frequently incontinent of urine. The resident's diagnoses included anxiety and depression. The Bathing record showed the resident's bath on 11/10/22 not applicable, and no bath between 11/7 and 13//22. The resident had no bath documented 12/2 to 12/7/22. On 12/5/22 at 1:48 p.m. Staff D, Certified Nursing Assistant (CNA), stated they had cut staffing, and they were just getting by with what they had before. She stated they did not get the resident's bath done. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) According to the MDS assessment dated [DATE] Resident #5 had long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with bathing. The resident's diagnoses included a cerebrovascular accident (stroke) and hemiplegia (paralysis of 1 side of the body) or hemiparesis (weakness on one side of the body). The resident's Bathing record lacked documentation that the resident had a bath between 11/17/22 and 11/24/22. 5) According to the MDS assessment dated [DATE] Resident #8 had long and short term memory problems and severely impaired skills for daily decision making. The resident depended on staff for bathing. The resident's diagnoses included non-Alzheimer's dementia. The resident's Bathing record lacked documentation of a bath between 11/8/22 and 11/15/22. On 12/8/22 at 11:47 a.m. the DON stated she knew there was a problem with getting the baths done. She expected a full bath done at least 2 times a week. The Resident Hygiene policy dated August 2021 identified the bath and shower standard directed to bathe each resident daily, to include a sponge and/or bed bath five times weekly (or more often, if needed) including a tub bath, whirlpool bath or shower at least twice weekly. Tub and whirlpool baths or showers were scheduled for each resident and were given at various times of the day, modified according to the resident's condition, preferences, and desires, whenever possible. Bathing included cleaning and trimming fingernails and toenails, shaving facial hair, washing the entire body, and shampooing resident's hair.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observations, clinical record reviews, and staff interviews the facility failed to provide activities to meet the needs of each resident for 5 of 5 residents reviewed (Resident #4, #6, #7, #9, and #10). The facility reported a census of 24 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #4 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident demonstrated independence with toilet use and supervision with personal hygiene. The resident had frequent incontinence of urine. The resident's diagnoses included anxiety and depression. On 12/5/22 at 10:05 a.m. the resident stated he went to some activities. There hadn't been much to go to lately. They needed something to do around there. 2) According to the MDS assessment dated [DATE] Resident #6 scored 15 on the BIMS indicating no cognitive impairment. The resident ambulated independently. Diagnoses included post traumatic stress disorder. The MDS documented it was very important for the resident to do things with groups, do her favorite activities, and religious services. On 12/5/22 at 10:30 a.m. the resident stated they aren't doing much for activities because they don't have an Activity Director. 3) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #7 had no memory problem and was independent with cognitive skills for daily decision making.The resident required limited assistance with ambulation in her room and the hall and extensive assistance with dressing, toilet use, and personal hygiene. The resident's diagnoses included anxiety disorder and depression. On 12/5/22 at 10:32 a.m. the resident said she chose which activities she wanted to go to, but there wasn't much to choose from. 4) According to the MDS assessment dated [DATE] Resident #9 scored 15 on the BIMS indicating no cognitive impairment. The resident required extensive assistance with activities of daily living including toilet use and personal hygiene. The resident's diagnoses included cerebral palsy. On 12/5/22 at 10:25 a.m.the resident stated she wouldn't go wrestling. She said it got boring sitting in the room all day. 5) According to the MDS assessment dated [DATE] Resident #10 scored 15 on the BIMS indicating no cognitive impairment. The resident required extensive assistance with activities of daily living including transfer, dressing, toilet use and personal hygiene. The resident's diagnoses included cerebral palsy and paraplegia (paralysis of the legs and lower body). On 11/28/22 at 1:50 p.m. the resident stated they didn't have hardly anything for activities and they needed something to do. (continued on next page)

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	165344	A. Building B. Wing	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The October Activity Calendar showed the weekdays had a variety of activities scheduled throughout the day. The evening had 7 p.m. Wrestling or Raw (TV Show), 10 of 31 days for the evening activity. The November 2022 Activity Calendar showed 7pm Wrestling (TV show) 20 out of 30 days as the evening activity. It was the only activity identified on Sundays (4 days). On Saturday at 6:30 p.m. Wheel of Fortune and 7 p.m. [NAME] were the only activities (4 days). Sixteen days had only 1 activity scheduled. Six days had 2 activities plus wrestling. On 11/28/22 4:13 p.m. the Administrator stated she had an Activity Director but she terminated about a month ago. On 11/30/22 9:10 a.m. Staff H, Housekeeping, stated she did some activities from 10/24/22 for 2 weeks. She did not do everything on the calendar. She made the activity calendar for November. The calendar contained 1 to 2 items each day and many times one of the activities was 7 p.m. wrestling which was on the TV in the family room. On 11/10/22 they put her on housekeeping only, not the activities. She said they are not doing the activities planned. She said on Monday they did not do the Indian corn beading. They did have Bingo, which the residents conducted. The job description of the Activity Director documented the primary purpose of the Activity Director position was to plan, organize, develop and direct the overall operation of the Activity Department.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42132 Based on observations, clinical record reviews, policy review, resident, and staff interviews the facility failed to adequately supervise a resident during the administration of eye drops for 1 of 1 resident reviewed (Resident #1) which resulted in fingernail glue being placed in a resident's eye. On 11/11/22, Resident #1 arrived in the dining room with a small bottle he found on his bedside table and asked Staff A, Certified Nurse Aide (CNA), to assist him with putting in eye drops. Staff A proceeded to administer the drops into Resident #1's right eye without confirming the bottle was eye drops. After Staff A placed a drop into Resident #1's right eye, the resident immediately complained of pain and burning. Staff A then identified the bottle as fingernail glue instead of eye drops. The local EMT's (emergency medical team) arrived at the facility and assisted Resident #1 with flushing his right eye. After 25 minutes of flushing Resident #1's eye, his eyelids broke apart. The facility reported a census of 24 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #1 dated 10/26/22, identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS coded the resident with adequate vision, able to read regular print in newspaper without corrective lenses. The MDS listed diagnoses of anxiety, depression, bipolar, and COPD (chronic obstructive pulmonary disease). The MDS revealed the resident had pain occasionally, that received scheduled pain medications, and he did not receive additional pain medications as needed. The facility incident report titled Unknown dated 11/11/22 at 10:50 PM, revealed: Nursing description: An agency CNA waiting for a ride when Resident #1 came to the dining room, attempting to put in eye drops and asked the CNA for assistance. The CNA placed the eye drops into Resident #1's right eye and then looked at the bottle, realizing then it was nail glue. The CNA reported to the charge nurse and left her shift. Resident description: Resident #1 stated he thought the bottle was eye drops and brought it out for assistance to administer. The resident stated he did not know the bottle was nail glue. Immediate action: call placed to 911 and the Emergency Medical Services (EMS) arrived to assess and flush his eye. The Progress Notes for Resident #1 revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. On 11/12/22 at 12:08 AM, a Health Status Note (HSN) revealed that at approximately 10:43 PM, the resident went to the dining room and asked Staff A to put in some drops in his eyes. Staff A proceeded to put drops in the resident's eye when the resident complained of burning. Staff A then identified the bottle to be nail glue. The resident stated he found the bottle on his bedside table. At 10:45 PM, the emergency services and the doctor on call were notified. The EMT's arrived at 10:58 PM and flushed the resident's eye for 20 minutes. During the flushing of the eye the resident received tramadol and Tylenol for pain. Once the eye was opened, his eye appeared red and the resident complained of blurry vision. At 11:30 PM, the on-call provider got notified of the outcome and requested a face to face to visualize Resident #1's eye. b. On 11/12/22 at 4:47 AM, a telemed note revealed the resident had an initial visit via telemedicine for superglue in the eye. The eye appeared to have slight redness, slight irritation, and no drainage. The resident denied changes in vision. c. On 11/12/22 at 11:13 AM, a telemed note revealed the resident got seen due to crazy glue being applied to his right eye the night before. The resident complained of pain 8 out of 10 to his right eye. The assessment of the right eye revealed visible swelling to the surrounding tissue, more to then to his lower lid. The conjunctiva was red and the resident complained of pain and burning. The resident reported distorted/blurry vision to his right eye. The provider requested the resident be sent to the emergency room (ER) for further evaluation and treatment. d. On 11/12/22 at 11:26 AM, HSN indicated notification of the on-call provider occurred on 11/11/22. The resident complained of blurred vision and rated his pain at an 8 out of 10. The resident's sclera was red with the surrounding area red and swollen. e. On 11/12/22 at 6:01 PM, the Medication Administration Note (MAN) revealed the resident received Tylenol 650 milligrams (mg)for pain rated at a 6 out of 10. f. On 11/12/22 at 7:19 PM, MAN revealed the resident received tramadol 50 mg for right eye pain g. On 11/13/22 at 1:29 AM, HSN revealed the resident's right eye was red and irritated. The resident complained of pain to his right eye. Resident #1 received tramadol and Tylenol to manage his pain. The resident reported the tramadol and the Tylenol were not controlling the pain to his right eye. The resident went to the ER and returned at approximately 6 PM, with a new order for erythromycin ointment four times a day to his right eye for seven days. h. On 11/13/22 at 1:14 PM, MAN revealed the resident received tramadol 50mg for pain in the right eye, rated 6 out of 10. i. On 11/14/22 at 1:22 PM, MAN revealed the resident received tramadol 50mg for pain to the right eye j. On 11/15/22 at 2:09 AM, HSN indicated the resident right eye continued with redness and antibiotic ointment applied. k. On 11/15/22 at 9:00 AM, HSN indicated the resident was seen by the primary care provider during an in-house visit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	l. On 11/15/22 at 12:27 PM, MAN revealed the resident received tramadol 50 mg for pain to his right eye. m. On 11/16/22 2:33 PM, HSN indicated the resident woke up most of the night and complained of discomfort to his eye. The right eye appeared red and the ointment applied. n. On 11/16/22 at 11:26 AM, MAN revealed the resident received tramadol 50 mg due to pain in his right eye. o. On 11/16/22 at 2:09 PM, HSN revealed the resident returned from an appointment with the optometrist (eye doctor) and received orders to continue the antibiotic ointment and start a steroid eye drop. The resident was to return to the clinic in two weeks for a follow-up appointment. p. On 11/30/22 at 3:10 PM, HSN revealed the resident returned from the eye appointment in order to discontinue the antibiotic ointment and continue with the steroid eye drops. The Emergency Services Prehospital Care Report dated 11/11/22, revealed that upon arrival at the facility Resident #1 sat in a wheelchair holding a warm cloth to his eye. Resident #1 gave the staff a bottle of what he originally thought was eye drops and had asked the CNA to administer. After the CNA administered the eye drops, she realized the bottle was nail glue. Resident #1's lashes were covered with a thick layer of glue and had to be flushed for 25 minutes. Resident #1's eye had to be pulled at the eyebrow and cheek to break the eyelids apart. Resident #1's eye was red and swollen. No transport required to the emergency room . The local hospital Emergency Department note dated 11/12/22 at 3:20 PM, identified Resident #1 reported irritation, redness, and pain to his right eye due to nail glue placed into his eye. Resident #1 reported tearing and blurred vision to the right eye. Suspected corneal irritation. The November Medication Administration Record (MAR) revealed Resident #1 received the medications below following the administration of nail glue in his right eye: a. Prednisolone 1% eye drops, apply one drop to the right eye two to four times a day from 11/17/22 - 11/30/22. b. Erythromycin eye ointment three to four times per day from 11/12/22 - 11/30/22. c. Tramadol 50 mg 1 tablet every 12 hours as needed, received daily 11/12/22 - 11/16/22. d. Tylenol 325 mg 2 tablets every six hours as needed, received 11/12/22. The facility investigation dated 11/12/22, identified Resident #1 had super glue placed in his eye by a CNA. The investigation revealed Resident #1 brought a bottle out of his room to Staff A holding the bottle over his eye and asked the CNA to assist him. Staff A placed the drops in the resident's eye and the resident immediately complained of his eye burning. Staff A noted the bottle to be nail glue and notified the nurse immediately. The facility Medication Administration Guidelines dated June 2022, revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. Only a licensed nurse would be allowed to administer medication as per the state/federal laws and regulations (follow the state policy on medication aide) b. Upon administering medication, the license nurse would compare the label on the medication to the Medication Administration Record (MAR) to ensure accuracy. c. The resident's MAR would be reviewed to determine what medications are to be administered and then the staff removes those medications from the medication cart d. The staff would compare the MAR with the label of each medication for: the right person, right medication, right date, right time, right route, right dose, and expiration date. The facility document titled Dress Code, undated indicated: a. Fingernails would be neat and not exceeding one-fourth inch in length for clinical and dietary staff b. Artificial gels and overlays not permitted for purposes of infection control On 11/28/22 at 10:35 AM, Resident #1 laid in bed with oxygen on at 4L/NC (liters/nasal cannula) with a tray table beside his bed that contained a water mug, cell phone, and a box that the resident stated contained ostomy supplies. The resident stated he never had been able to keep eye drops in his room, however, on 11/11/22, he saw a small bottle on his tray table and assumed the small bottle was eye drops so he took the bottle to the front and asked the CNA to put drops in his eyes. Resident #1 stated his eyes were too bad and he could not read the label on the bottle. The resident stated the CNA did not read the bottle and just put a drop into his right eye. Resident #1 stated as soon as the CNA put the eye drop into his right eye, he felt pain immediately. The resident stated the CNA then read the bottle and stated it was a bottle of fingernail glue, not eye drops. The resident stated the EMT's (Emergency Medical Team) came to the facility and applied heat compression to open the right eye. The resident stated boy it sure hurt, when the fingernail glue was placed into my right eye. Resident #1 stated the EMT's had worked for approximately 45 minutes to get the glue out of his eye, and to where he was able to open his eye. Resident #1 stated he went to the ER (emergency room) for further evaluation of the right eye and within two days saw an eye doctor. The resident stated the eye doctor informed him that the right eye wouldn't bother him forever, however, he continued to have blurry vision. Resident #1 stated when he saw the bottle on the tray table, he assumed the bottle was eye drops due to recently complaining to the staff about dry eyes. Resident #1 stated he did not know why the fingernail glue was in his room, on the tray table or where the glue came from. Resident #1 stated he was not allowed to have any medications left in his room, before, or after the incident on 11/11/22. Resident #1 stated he was not aware of any staff being in his room that could have left the fingernail glue on the tray table. The resident stated the bottle was artificial fingernail glue and that he was sure one of the facility staff girls left it in his room. The resident stated one of the facility staff must have left the bottle of glue in his room sometime during the day on 11/11/22. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/28/22 at 12:04 PM, Staff B, CNA, confirmed that she worked 6 AM - 2 PM on 11/11/22. Staff B stated she did not have artificial nails and that Staff G, CMA (Certified Medication Aide), had artificial nails. Staff B stated she never recalled seeing a bottle of glue on Resident #1's bedside table. Staff B stated she was not aware if the resident had ever received eye drops in his eyes prior to the incident. Staff B stated if a resident had asked her to administer eye drops, she would tell the resident that she was unable to administer eye drops and that she would notify the nurse on duty. On 11/28/22 at 12:06 PM, Staff C, CMA, confirmed that she worked on 11/11/22. Staff C stated she did not have artificial nails. Staff C stated she did not recall seeing a bottle of nail glue on Resident #1's bedside table on 11/11/22. Staff C stated she never observed nail glue in any other residents' rooms. Staff C stated no residents were allowed to have medications in their room, including eye drops and inhalers, to self-administer. Staff C stated if a resident had approached her with eye drops to administer, she would give the bottle to the nurse on duty because the resident should not have eye drops in their room. On 11/28/22 at 12:10 PM, Staff D, CNA, confirmed she worked 6 AM - 2 PM on 11/11/22. Staff D stated she did not recall seeing a bottle of nail glue on Resident #1's tray table on the day of 11/11/22. Staff D stated she did not have artificial nails. Staff D stated she had never observed any nail glue in other resident rooms. On 11/28/22 at 12:18 PM, Staff G confirmed that she worked 6 AM - 6 PM on 11/11/22. Staff G stated that she did not recall seeing a bottle of nail glue in Resident #1's room on 11/11/22. Staff G stated the only things Resident #1 kept on the tray table was water, cell phone, wheelchair charger, Kleenex and ostomy supplies. Staff G stated the resident had never asked about anything in his room, like something being left in his room. Staff G stated she did have artificial nails; however, she kept the nails short and never carried a bottle of nail glue while at work. Staff G stated she did not recall seeing a bottle of nail glue being left in any other residents' room. Staff G stated there was never a reason to have a bottle of nail glue in the facility. Staff G stated all chemicals in the facility were locked up away from the residents. Staff G stated there was one resident in the facility that had nails done regularly, however, done outside of the facility and not artificial nails, shellac polish. Staff G stated the resident's family took that resident out of the facility to have nails done. Staff G stated if a resident for assistance with eye drops, if clocked out would have the resident ask the nurse. Staff G stated she would confirm the bottle the resident had was eye drops because the residents are not to have eye drops in their room. Staff G stated she would then check to confirm the resident had an order for the eye drops. Staff G stated Resident #1 did not have an order for scheduled or as needed eye drops and the resident rarely asked for anything as needed with the exception of his inhaler. Staff G stated Resident #1 had never complained of having dry eyes. On 11/28/22 at 1:02 PM, Staff H, Housekeeper, stated she had not observed any fingernail glue in any of the residents' rooms and was shocked that Resident #1 had fingernail glue in his room and that staff had thought it was eye drops. Staff H stated several female facility staff had long artificial fingernails, the aides and the nurses. Staff H stated she had previously worked in activities for a couple of weeks and the resident's activity supplies; fingernail polish and the nail polish remover were kept in the locked cupboard. Staff H stated the facility did not currently have an activity assistant and was not aware of when the last time the residents had their nails done. Staff H state some residents may have nail polish in their rooms, but no nail polish remover or nail glue. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/28/22 at 2:00 PM, Staff A confirmed she worked at the facility 2 PM - 10 PM on 11/11/22 as an agency staff. Staff A stated she had clocked out about 30 minutes prior around 10 PM and had been waiting for her ride. Staff A stated about 10:30 PM her ride showed up and she grabbed things to leave when as she walked to the door Resident #1 came up in his electric wheelchair with a bottle hovering over his eye and asked if she would help him get his eye drop in. Staff A stated instead of telling the resident she was not clocked in, she tried to be helpful and gave Resident #1 the eye drops. Staff A stated as soon as she gave Resident #1 the drop in the right eye, the resident bent down and complained of the eye burning. Staff A stated at that time looked at the bottle, and saw it was nail glue not eye drops. Staff A stated she had asked the resident where he got the bottle from and he said it was on his table. Staff A stated she didn't know where the bottle of nail glue came from or why it was even in the facility. Staff A stated she did not know why the bottle was there or how it got there. Staff A stated the facility wouldn't allow her to return to the facility to work due to the incident. Staff A stated she admitted , she put the nail glue in Resident #1's eye, however, did not leave the nail glue in the resident's room. Staff A stated the way Resident #1 came up to her with the bottle over his he was attempting to self-administer so she assumed the bottle was eye drops. Staff A stated tried to be helpful and gave the resident the drops even though she was off the clock. Staff A stated she did not recall seeing the bottle of nail glue in the resident's room during the 2 PM - 10 PM shift. Staff A stated she took responsibility for what she did, putting the nail glue in the resident's eye. Staff A stated if they could go back and change, they wouldn't have assisted the resident with the drops. Staff A stated she was not surprised something like the nail glue was left in the residents, stated the facility was chaotic and had no organization. Staff A stated her first day to work at the facility was Friday 11/11/22 and the facility allowed her to work on Saturday 11/12 and Sunday 11/13, however, was then not allowed to return to the facility to work. On 11/28/22 at 2:56 PM, Staff E, CNA, confirmed that she worked 10 PM - 6 AM on 11/11/22. The 2-10p aide in the dining room had been waiting for a ride. The other night CNA and Staff E were down the hall and as we were coming to the dining room saw the 2 PM - 10 PM aide start to put the drop in the resident's eye. Did not see the resident trying to put drops in his own eye. The resident did bring the bottle of nail glue from his room. The resident had asked the 2 PM - 10 PM aide for assistance and then the resident put his head down immediately. We were through the dining room and the aide looked at the bottle and said it was nail glue. Never observed nail glue left in another resident's room. Too many staff have acrylic nails and I don't think they should have them. If they kept them short but we have too many with nails that are too long. As few staff as the facility had, probably the agency that has the acrylic nails. Did not witness, heard Staff A say she had placed nail glue in Resident #1's eye. The EMT's came right away and assisted with getting the resident's eye open. The facility had a policy regarding nails, and to be quarter inch in length. Did not think the facility had a policy related to fake nails specifically but the length. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/28/22 at 3:09 PM. Staff F, CNA, confirmed she worked 10 PM - 6 AM on 11/11/22. Staff F stated she had received a report with the other overnight aide (Staff E) and observed Staff A at the table in the dining room, awaiting her ride. Staff F stated she went down the north hall with Staff E to answer a call light and when coming back up the hall observed Staff A standing over Resident #1. Staff F stated she observed Staff A lean over Resident #1 and then heard the resident complain of his eye burning. Staff F stated she asked Staff A what she was doing and Staff A stated Resident #1 had asked for assistance with putting in eye drops and Staff A said it was nail glue. Staff F stated Resident #1's eye instantly was glued shut. Staff F stated the nurse informed us to place a warm rag on the resident's eye and called 911. Staff F stated Staff A had been on her phone at the time and picked up her belongings. As Staff A walked to the door she said into her phone, you wouldn't believe what just happened. Staff F stated the EMT's were at the facility for about 20 minutes to flush the Resident #1's eye. Staff F stated the resident had never asked for eye drops to be placed before, stating the resident knew the nurse would give him the eye drops. Staff F stated Resident #1 had informed the staff that the nail glue had been on his bedside table. On 11/28/22 at 3:40 PM, the Director of Nursing (DON) stated that she received a phone call from the facility on 11/11/22 that a CNA had placed nail glue in Resident #1's eye, instead of eye drops. The DON stated Resident #1 had an order for artificial tears as needed, however, the resident was not allowed to keep those in his room. The DON stated Staff A thought she was just helping the resident out because his hand was not steady enough to administer the eye drops. The DON stated the EMT's were at the facility and stayed for approximately 30-45 minutes to flush the Resident #1's eye and the EMT's took the nail glue. The DON stated Resident #1 was seen by telehealth on the night the incident occurred and then the following day. The DON stated Resident #1 went to the local emergency room (ER) the following day as recommended for further evaluation on 11/12/22. Resident #1 returned to the facility from the ER visit with orders for erythromycin ointment. Resident #1 went to the eye doctor on 11/16/22 and would return for a follow-up visit on 11/30/22. The DON stated Resident #1 had an order for artificial tear eye drops as needed, however, the resident was not allowed to keep the eye drops in his room. The DON stated no residents in the facility were allowed to keep their own medications in their room. The DON stated she had asked Resident #1 and the facility staff where the nail glue came from and none of them knew where the nail glue came from. Resident #1 saw the bottle on his table and assumed it was an eye drop. The DON stated Staff A had been at the table and Resident #1 came out with the bottle above his eye and asked Staff A to assist with putting the eye drops in due to the resident hand not steady. The DON stated Staff A thought she was helping Resident #1 because his hand was not steady enough to administer the eye drops himself.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42132 Based on staff personnel file review, clinical record reviews, facility policy review, facility investigation, resident, and staff interviews the facility failed to ensure staff who attempted to administered eye drops were qualified staff for 1 of 1 resident reviewed (Resident #1). The facility reported a census of 24 residents. Findings include: Staff A's, Certified Nurse's Aide (CNA), personnel file revealed an active CNA license with an expiration date of 7/6/24. The facility investigation titled State Reportable 5 Day Investigation/Summary Report dated 11/12/22, identified: a. The summary of the incident that occurred was super glue placed into a resident's eye by a CNA. b. The conclusion of the investigation indicated the CNA was an agency staff member. The facility told the agency that she was not allowed to return to the facility. The DON re-educated the nursing staff on who could and could not administer medications based on their scope of practice. The facility job description for a CNA dated May 2017, revealed: a. The CNA would function under the direction of a licensed nurse and within the standards of practice as accorded by their certification b. The CNA performed various patient care activities and related non-professional services essential to caring for personal needs and comfort for the residents. The facility Medication Administration Guidelines dated June 2022, revealed: a. Only a licensed nurse would be allowed to administer medication as per the state/federal laws and regulations (follow the state policy on medication aide). b. Upon administering medication, the licensed nurse would compare the label on the medication to the Medication Administration Record to ensure accuracy. (continued on next page)

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Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/28/22 at 10:35 AM, Resident #1 laid in bed with oxygen on at 4L/NC (liters/nasal cannula) with a tray table beside his bed that contained a water mug, cell phone, and a box that the resident stated contained ostomy supplies. The resident stated he never had been able to keep eye drops in his room, however, on 11/11/22, he saw a small bottle on his tray table and assumed the small bottle was eye drops so he took the bottle to the front and asked the CNA to put drops in his eyes. Resident #1 stated his eyes were too bad and he could not read the label on the bottle. The resident stated the CNA did not read the bottle and just put a drop into his right eye. Resident #1 stated as soon as the CNA put the eye drop into his right eye, he felt pain immediately. The resident stated the CNA then read the bottle and stated it was a bottle of fingernail glue, not eye drops. The resident stated the EMT's (Emergency Medical Team) came to the facility and applied heat compression to open the right eye. The resident stated boy it sure hurt, when the fingernail glue was placed into my right eye. Resident #1 stated the EMT's had worked for approximately 45 minutes to get the glue out of his eye, to where he was able to open the eye. On 11/28/22 at 12:04 PM, Staff B, CNA, stated if a resident had asked her to administer eye drops, she would tell the resident she was unable to administer eye drops and notify the nurse on duty. On 11/28/22 at 12:06 PM, Staff C, CMA, stated no residents were allowed to have medications in their room, including eye drops and inhalers, to self-administer. Staff C stated if a resident had approached her with eye drops to administer, she would give the bottle to the nurse on duty because the resident should not have eye drops in their room. On 11/28/22 at 12:10 PM, Staff D, CNA, stated if a resident had asked her to administer eye drops she would tell them she was unable to administer the eye drops due to it not being in her scope of practice. On 11/28/22 2:00 PM, Staff A, CNA, confirmed that she worked at the facility on 11/11/22 from 2 PM - 10 PM as an agency staff member. Staff A stated she clocked out about 30 minutes prior to the incident around 10 PM and had been waiting for her ride. Staff A stated about 10:30 PM her ride showed up and she grabbed her things to leave. As she walked to the door Resident #1 came up in his electric wheelchair with a bottle hovering over his eye and asked if she would help him get his eye drop in. Staff A stated instead of telling the resident she was not clocked in, she tried to be helpful and gave Resident #1 the eye drops. Staff A stated as soon as she gave Resident #1 the drop in the right eye, the resident bent down & complained of his eye burning. Staff A stated then at that time she looked at the bottle, and saw it was nail glue not eye drops. Staff A stated she had asked the resident where he got the bottle from and he said it was on his table. Staff A stated she didn't know where the bottle of nail glue came from or why it was even in the facility. Staff A stated she did not know why the bottle was there or how it got there. Staff A stated the facility wouldn't allow her to return to the facility to work due to the incident. Staff A stated she admitted , she put the nail glue in Resident #1's eye, however, did not leave the nail glue in the resident's room. Staff A stated tried to be helpful and gave the resident the drops even though she was off the clock. Staff A stated she took responsibility for what she did, putting the nail glue in the resident's eye. Staff A stated if they could go back and change it, they wouldn't have assisted the resident with the drops. On 11/28/22 at 2:56 PM Staff E, CNA, confirmed they worked 10 PM - 6 AM on 11/11/22. Staff E stated they observed Staff A bent over Resident #1 and Staff A proceeded to put a drop in the resident's eye. Staff E stated Resident #1 had immediately put his head down and Staff A then looked at the bottle and said it was nail glue and not eye drops. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/28/22 at 3:09 PM Staff F, CNA, confirmed they worked 10 PM - 6 AM on 11/11/22. Staff F stated she observed Staff A leaned over Resident #1 and then heard the resident complain of burning. Staff F stated she asked Staff A what she was doing. Staff A replied that Resident #1 asked for assistance with putting in eye drops and then Staff A said it was nail glue. On 11/28/22 at 3:40 PM the Director of Nursing (DON) stated they received a phone call from the facility on 11/11/22 that a CNA placed nail glue in Resident #1's eye, instead of eye drops. The DON stated Resident #1 had an order for artificial tears as needed, however, the resident was not allowed to keep those in his room. The DON stated Staff A thought she was just helping the resident out because his hand was not steady enough to administer the eye drops.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42132 Based on clinical record reviews and staff interviews the facility failed to ensure a resident received an antibiotic as ordered for 1 of 2 residents reviewed (Residents #15) taking oral antibiotics. The facility reported a census of 24 residents. Findings Include: Resident #15's Minimum Data Set (MDS) assessment dated [DATE], for, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS listed diagnoses of HTN (hypertension), diabetes, and non-Alzheimer's dementia. The Care Plan with a target date of 12/14/22, identified that Resident #15 had a urinary tract infection (UTI) related to incontinence. The Care Plan Interventions included: a. Encourage adequate fluid intake b. Give the antibiotic therapy as ordered. Monitor/document side effects and effectiveness. c. Monitor/document/report the physician as needed for signs and symptoms of UTI: frequency, urgency, fatigue, foul smelling urine, difficulty urinating, fever, nausea, vomiting, flank pain, blood in the urine, cloudy urine, altered mental status, loss of appetite, and behavioral changes. d. Resident/family/caregiver teaching would include: good hygiene practices, females to wipe and cleanse from the front to the back, clean peri area after a bowel movement to help prevent bacteria in the urinary tract, cranberry juice or prune juice to help keep urine acidic, void at first urge,., clean underwear daily, do not hold urine for an extended period of time, take the full course of the antibiotic therapy even if improvement after a few days of therapy. The Progress Notes for Resident #15 revealed: a. On 11/29/22 at 9:07 AM, communication with family revealed the resident's family member called the facility regarding concerns over the resident's change in status. The facility nurse discussed with the family member making an appointment to be seen by her primary care provider to check lab work and a urinalysis. The facility nurse noted the resident had complained of increased urinary frequency and urgency. The family member would call the clinic to schedule an appointment and get back to the facility. The family member voiced concern regarding cognition changes with the resident. b. On 11/29/22 at 1:29 PM, a Health Status Note (HSN) revealed a second family member arrived at the facility to visit the resident, they requested the resident be tested for COVID-19 (novel coronavirus 2019), and the resident tested positive. The second family member requested the resident be transferred to the local emergency room (ER) for evaluation. Documentation revealed the resident had been in her room the past 2 days with no appetite and no energy. c. On 11/29/22 at 1:50 PM, HSN revealed the resident left the facility via the ambulance to the local ER. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 11/29/22 at 7:15 PM, HSN revealed the resident returned from the local ER via a private vehicle, accompanied by the second family member. Two staff assisted the resident into the facility. The resident would be in isolation for four days due to a diagnosis of COVID-19. The hospital sent an order to the pharmacy for Cephalexin 500 milligrams (mg) four times a day for 10 days. e. On 11/30/22 at 6:00 PM, HSN indicated the resident continued to be in isolation due to being COVID positive (+). The resident reported to be feeling better than the previous day. The resident denied coughing, however, continued to have nasal congestion with clear nasal drainage. The resident received an order for antibiotics for a UTI per the ER visit. The antibiotic was sent to the pharmacy and the facility had not yet received the antibiotic. f. On 12/1/22 at 11:55 AM, an order note indicated the second family member called the facility and was upset that the facility had reported the ER visit paperwork was missing and the resident had not yet received their antibiotic as ordered for their UTI. The facility nurse called the pharmacy and the pharmacy reported they did not receive the order for the antibiotic. g. On 12/1/22 at 12:04 PM, HSN revealed the night nurse from 11/29/22 and the day nurse from 11/30/22 stated the resident's antibiotic prescription had been sent to the pharmacy, however, neither of the nurses had followed up with the pharmacy. h. On 12/1/22 at 5:02 PM, the Medication Administration Notes indicated the Cephalexin 500 mg had been given. The After-Visit Summary document from the local ER dated 11/29/22, revealed: a. Instructions: 1. Your medications changed today 2. Urinary Tract Infection 3. Pick up these medications at the pharmacy - Cephalexin (antibiotic) b. Start taking these medications: Cephalexin 500 mg, one capsule four times a day for 10 days. The November 2022 Medication Administration Record (MAR) for Resident #15, lacked the order for Cephalexin from 11/29/22. The December 2022 MAR for Resident #15 revealed an order for Cephalexin 500mg four times a day related to UTI for 10 days. Documentation revealed the first dose administered in the evening of 12/1/22. The facility failed to initiate Resident #15's antibiotic for a UTI on 11/29/22 when ordered by the physician until 12/1/22, in the evening. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/22 at 10:01 AM, Staff L, Licensed Practical Nurse (LPN), stated that when she worked on 11/30/22 at 6 AM, she received report that Resident #15 had an order for an antibiotic from the ER visit on 11/29/22. Staff L stated she had asked the night nurse if the order had been sent to the pharmacy and the night nurse informed her, discharge papers from the ER indicated the antibiotic order was sent to the pharmacy. Staff L stated she reviewed the ER paperwork with the night nurse and the antibiotic had been sent to the pharmacy by the hospital on 11/29/22. Staff L stated she did not call the pharmacy on 11/30/22, to follow-up because she expected the doctor to take care of ordering the antibiotic from the pharmacy as indicated on the ER paperwork. Staff L stated she probably should have called the pharmacy on 11/30/22, and asked about the antibiotic, but it was documented that the order was sent to the pharmacy. Staff L stated she was not aware until 12/1/22 that Resident #15 had not gotten the antibiotic as ordered on 11/29/22 until 12/1/22. Staff L confirmed the pharmacy the facility utilized was the pharmacy listed on the after-visit summary from the ER. During a review with Staff L, the after-visit summary indicated to pick up the medications and Staff L stated the facility never picked up medications from the pharmacy, the pharmacy delivered the medication every night after 6 PM. Staff L stated she figured the antibiotic would be delivered on the evening of 11/30/22, after she had left for the day. Staff L stated Resident #15 returned from the ER after 6 PM on 11/29/22, and would expect the antibiotic to be delivered to the facility after 6 PM on 11/30/22. Staff L stated she was unaware if the emergency kit (E-kit) at the facility contained cephalexin, however, stated she did not think to look in the E-kit for the antibiotic on 11/30/22. Staff L stated Resident #15 returned from theER on [DATE] at 7:15 PM and she was not at the facility. Staff L stated she thought at times, the facility nurses would get medications out of the E-kit to administer to the residents until the pharmacy delivered the medications, however, she had not used the E-kit much. Staff L stated she was not going to lie, she forgot about the E-kit on 11/30/22, to utilize for the resident's antibiotic. Staff L stated she when the order was received on 11/29/22 at 7:15 PM upon Resident #15's return from the ER, she would not expect the antibiotic to be delivered from the pharmacy until after 6 PM on 11/30/22. Staff L confirmed Resident #15 could have already had 3-4 doses of antibiotic by utilizing the E-Kit until the pharmacy delivered the medication. Staff L stated again, she did not think about getting the antibiotic from the E-kit for Resident #15 on 11/30/22. On 12/6/22 at 1:53 PM, the Interim Director of Nursing (IDON) stated when she was made aware of Resident #15 not getting antibiotics for her UTI as ordered on 11/29/22, she called the two nurses involved and took care of it. The IDON stated the two nurses informed her they did not think to call the pharmacy because the ER had sent the order to the pharmacy. The IDON confirmed Resident #15 did not receive her first dose of antibiotic until the evening of 12/1/22, when the antibiotic had been ordered on 11/29/22. When asked the IDON if she would expect the nurses to utilize the E-kit, the IDON shrugged her shoulders and stated the ER nurse had told the facility nurse the evening of 11/29/22, that the ER would send enough of the antibiotic to be given until the script was delivered by the pharmacy.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 26527 Based on staff interviews and document review the facility failed to complete the required directed plan of correction (DPOC) for the facilities previous survey ending on 10/20/22. The facility reported a census of 24 residents. Findings include: On 12/8/22 at 12:57 PM the Administrator stated they had sent in their plan of correction for the previous survey. She was not aware it needed some revision. She took vacation the week of 11/22/22. She had not been through all her emails. She checked the emails and found the one explaining what needed done. On 11/21/22 the facility submitted a plan of correction via email. On 11/22/22, the State Long Term Care Program Coordinator (PC) #1 notified the Administrator and Corporate Representative that the Plan of Correction lacked the corrective dates for each deficiency. In addition, the Plan of Correction lacked the required Directed Plan of Correction (DPOC). The PC #1 directed that the facility had until 11/26/22 to submit the documentation that the facility would or had completed the DPOC. On 11/30/22 the PC #2 notified the facility to send the completed DPOC to them for review. As of 12/8/22 the facility has not submitted the required DPOC for review. On 12/8/22 at 1:11 PM the Administrator reported a correction date of 11/21/22. On 12/8/22 at 1:50 PM the Administrator notified PC#2 that the facility's previous Regional Nurse Consultant (RNC) was working with on the DPOC. With the change in RNC's, the new RNC was working on the DPOC. The Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Ref: QSO-20-31-All revised 1/4/21 directed that while the Centers for Medicaid and Medicare Services (CMS) infection control deficiencies have been an ongoing compliance concern, the COVID-19 pandemic highlights the imperative that nursing home staff adhere to these fundamental health and safety protocols. Due to the heightened threat to resident health and safety for even low-level, isolated infection control citations (such as proper hand-washing and use of personal protective equipment (PPE)), CMS is expanding enforcement to improve accountability and sustained compliance with these crucial practices. In addition to enhanced enforcement, CMS is also providing Directed Plans of Correction, including the use of Root Cause Analysis, to facilitate lasting systemic changes within facilities to drive sustained compliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42132 Based on observations, review of the Centers for Disease Control and Prevention (CDC), clinical record reviews, facility policy review, and staff interviews the facility failed to utilize the infection control practices as directed by the CDC for 1 of 1 resident reviewed (Resident #15) in isolation for novel Coronavirus 2019 (COVID-19). On 11/29/22 Resident #15 received a diagnosis of COVID-19. At the time, the facility failed to have the proper personal protective equipment (PPE) available for the staff while providing care for the resident. The facility reported a census of 24 residents. Findings Include: The Minimum Data Set (MDS) assessment for Resident #15 dated 11/18/22, identified a Brief Interview for Mental Status of score of 15, indicating no cognitive impairment. The MDS listed diagnoses of HTN (hypertension), diabetes, and non-Alzheimer's dementia. The Care Plan for Resident #15, with a target date of 12/14/22, identified the resident had a respiratory infection related to chronic disease processes, COVID positive (+) on 11/29/22, and in isolation for 5 days. The Care Plan interventions included: a. Oxygen at 1 liter per nasal cannula (L/NC) b. Activity as tolerated, to help increase lung expansion c. Emphasize good hand washing techniques to all direct care staff d. Encourage fluid intake e. Isolation precautions f. Medications/treatments as ordered by the physician g. Monitor/document level of consciousness and any changes h. Monitor/document breath sounds, rate, rhythm, and the use of any accessory muscles i. Monitor/document/report to the physician as needed for signs and symptoms of dehydration, dry skin and mucous membranes, poor skin turgor, weight loss, fatigue, hypotension, increased heart rate, fever, or abnormal electrolyte levels Observations of Resident #15's room on 12/1/22 at 9:00 AM and on 12/6/22 at 12:27 PM revealed the door closed with a sign posted directing the use of droplet isolation and to utilize the following: gown, N95 mask, gloves, hairnet, booties, and a face shield. A 3-drawer cupboard to the left of the door contained gloves, hand sanitizer, face shields, eye protection, surgical masks, and N95 masks. The observations occurred at the following times (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes for Resident #15 revealed the resident had tested positive for COVID-19 on 11/29/22 at 1:29 PM. The facility's policy titled COVID-19 Protocol Phase IV: a. Section Receiving a Positive COVID-19 results, instructed that staff would change to an N95 mask for care and services b. Section Effective 3/31/21, inventory of PPE would be monitored daily and replenished as indicated c. Section Updated 9/10/21, staff caring for residents with COVID-19 should wear full PPE (gowns, gloves, eye protection, and N95 masks) d. Section Updated 10/11/21, identified that during periods of substantial to high transmission during an outbreak, staff would wear eye protection and N95 masks and all staff would wear appropriate PPE while interacting with the residents. The facility's Infection Control Manual titled Pandemic dated March 2020, under the section during a pandemic, PPE included: N95, in the event of shortage of N95 masks the N95 would be provided for high-risk staff. N95 masks could be reused as long as the mask was not contaminated by secretions, was labeled with the employee's name and stored in a clean paper bag. The N95 must be discarded if it becomes wet or contaminated. On 12/6/22 at 9:33 AM, the Interim Director of Nursing (IDON) stated the facility had one positive COVID-19 resident in the facility and the resident was in isolation precautions. The IDON stated Resident #15 tested positive for COVID-19 on 11/29/22. On 12/6/22 at 9:04 AM, Staff F, Certified Nurses Aide (CNA), stated Resident #15 had tested positive for COVID-19 on 11/29/22 and when she worked at 10 PM on 11/30/22, there were no N95 masks in the facility. Staff F stated the staff were required to wear N95 masks while in Resident #15 rooms due to the resident being COVID-19 positive. Staff F stated she had texted the IDON on 11/30/22 at 11:47 PM, that the staff were unable to find N95 masks and Resident #15 required assistance from the staff to go to the bathroom. Staff F stated she had worked with Staff M, Registered Nurse (RN), on the night of 11/30/22. Staff M informed Staff F that when caring for a COVID-19 positive resident, they were required to wear an N95 mask. Staff F stated the IDON never responded to the text messages that were sent to her. Staff F explained that the staff called the IDON but received no response. Staff F stated she was not vaccinated for COVID-19 and did not want to spread the COVID-19 virus to the other residents. Staff F stated Resident #15's door had a sign posted that informed the staff an N95 mask was to be worn when entering the resident's room. Staff F stated she had searched the entire facility; upstairs, downstairs, and the supply closets and was unable to locate N95 masks. Staff F stated Staff M had checked the medication room and was unable to find N95 masks. Staff F stated they only had regular surgical masks available to utilize on the night of 11/30/22. Staff F explained that Staff M and herself took care of Resident #15 on 11/30/22 without N95 masks. Staff F reported that she had not worked since the night of 11/30/22 and was not aware of when the facility obtained N95 masks. Staff F stated she thought it was a requirement for staff to wear N95 masks while caring for COVID positive residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A screenshot of the text message provided by Staff F revealed that Staff F sent a text message to the IDON on 11/30/22 at 11:47 PM about them being unable to find any N95 masks. Staff F informed the IDON that she had looked downstairs and in the storage room. Staff F sent additional text messages to the IDON on 12/1/22 at 6:53 AM, 6:54 AM, and 1:24 PM regarding staffing and questioning the IDON if she had received the messages. There were no text message responses from the IDON until 12/1/22 at 1:41 PM, when the IDON responded about the scheduling issues. On 12/6/22 at 11:36 AM, Staff M confirmed that he had worked 6 PM - 6 AM on 11/30/22. Staff M stated he provided care to Resident #15 on 11/30/22, however, he attempted to reduce his time in the room. Staff M confirmed Resident #15 tested positive for COVID-19 on 11/29/22. Staff M stated the facility did not have N95 masks available on the night of 11/30/22, when caring for Resident #15. Staff M stated Staff F informed him there were no N95 masks and he had checked the 3 drawer cart outside of Resident #15 rooms and there were none. Staff M stated Staff F had gone downstairs to locate additional N95 masks and was unable to locate the masks. Staff M stated he placed 2 surgical masks on due to no N95 mask being available to assist Resident #15 to the bathroom. Staff M stated Staff F had notified the IDON regarding the facility not having any N95 masks available and the IDON never responded. Staff M stated he did not know what else to do besides utilizing 2 surgical masks due to not wanting Resident #15 to fall and the resident required assistance from the staff. Staff M stated he had checked in the medication room for additional N95 masks and was unable to locate any N95 masks. On 12/6/22 at 12:31 PM, Staff B, CNA, stated that when Resident #15 tested positive for COVID-19 on 11/29/22, the facility did not have N95 masks available to wear while caring for the resident. Staff B stated the staff took it upon themselves to wear surgical masks in order to care for the resident. On 12/6/22 at 1:33 PM, the IDON confirmed Resident #15 tested positive for COVID-19 on 11/29/22. The IDON stated she had been called on 11/30/22 regarding the night staff not having any N95 masks to care for Resident #15, who was COVID-19 positive and that she had brought N95 masks to the facility that night. The IDON stated the extra PPE supplies were kept across the street in an apartment and the staff knew that. The IDON stated she re-educated the staff and placed a note in the computer system for the staff regarding where the extra PPE supplies were located. The IDON stated it was the first she had heard that Staff M had worn 2 surgical masks to care for Resident #15 on 11/30/22 due to no N95 masks being available. On 12/6/22 at 1:35 PM, the Administrator questioned the IDON about extra PPE supplies being kept in the basement and the IDON stated only briefs were kept in the basement, the N95 masks were across the street in the apartment. The Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 9/23/22 retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html included a section regarding Personal Protective Equipment that directed a Health Care Provider (HCP) who entered the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, a gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

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Aspire of Gowrie	1808 Main Street Gowrie, IA 50543

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 42132 Based on staff interviews and the Centers for Medicare & Medicaid Services (CMS) the facility failed to provide the residents with a certified Infection Control Nurse that completed the specialized training related to infection prevention and control. The facility identified the Interim Director of Nursing (IDON) as the Infection Preventionist who did not complete the specialized training. The facility reported a census of 24 residents. Findings Include: On 12/6/22 at 1:53 PM, the IDON identified herself as the Infection Preventionist and that she was not certified. She reported that she had not taken the specialized training related to infection control and prevention. The Center of Clinical Standards and Quality/Survey & Certification Group Ref: QSO-20-38-NH revised 4/27/21, indicated the Infection Preventionist should complete the specialized training in infection prevention and control.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report COVID19 data to residents and families. 42132 Based on clinical record reviews, staff interviews, and review of the Centers for Medicare and Medicaid Services (CMS) recommendations the facility failed to notify all residents, residents' representatives, and their families by 5 PM, the next calendar day following the occurrence of a single confirmed case of COVID-19 in the facility. The facility reported the first positive case of confirmed COVID-19 (novel coronavirus 2019) on 11/29/22. The facility failed to have documentation to indicate representatives or families were notified of COVID-19 in the building. The facility reported a census of 24 residents. Findings Include: On 12/1/22 at 10:00 AM, the Interim Director of Nursing (IDON) stated the facility had one positive COVID-19 resident in the facility and the resident was in isolation precautions. The IDON stated the resident had tested positive for COVID-19 on 11/29/22. 1. The Minimum Data Set (MDS) for Resident #3 dated 11/29/22 revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive impairment. The Clinical Resident Profile for Resident #3 listed a family member as the responsible party and the emergency contact. The resident's clinical record for Resident #3 lacked documentation from 11/30/22 - 12/7/22, that the family had been notified of confirmed COVID-19 in the facility. 2. The MDS for Resident #10 dated 11/7/22, revealed a BIMS score of 15, indicating no cognitive impairment. The Clinical Resident Profile for Resident #10 listed a family member as the responsible party and the emergency contact. The resident's clinical record for Resident #10 lacked documentation from 11/30/22 - 12/7/22, that the family had been notified of confirmed COVID-19 in the facility. 3. The MDS for Resident #5 dated 9/22/22, identified the resident with short term and long-term memory problems and severely impaired cognitive skills for daily decision making. The Clinical Resident Profile for Resident #5 listed a guardian as the responsible party and the emergency contact. The resident's clinical record for Resident #5 lacked documentation from 11/30/22 - 12/7/22, that the family had been notified of confirmed COVID-19 in the facility. 4. The MDS for Resident #8 dated 11/3/22, identified the resident with short term and long-term memory problems and severely impaired cognitive skills for daily decision making. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Clinical Resident Profile for Resident #8 listed a family as the responsible party and the emergency contact. The resident's clinical record for Resident #8 lacked documentation from 11/30/22 - 12/7/22, that the family had been notified of confirmed COVID-19 in the facility. On 12/6/22 at 9:33 AM, the IDON stated the facility continued to have only one resident that had tested positive for COVID-19 and continued to be in isolation. The IDON stated no other residents had tested positive of COVID-19. On 12/6/22 at 1:33 PM, the IDON stated one new COVID positive resident in the facility was not an outbreak. The IDON confirmed 2 facility staff members had tested positive for COVID-19 between 12/2 and 12/4/22. On 12/6/22 at 1:53 PM, the IDON stated that only the resident's family that had been notified of a confirmed COVID-19 case was the family of the resident who had tested positive on 11/29/22. The IDON stated no other resident representatives and/or family members of the current 24 residents had been notified when the facility had a positive COVID-19 case. The CMS QSO-20-29 NH dated 5/6/20, under the Infection Control section, COVID reporting: the facility must inform residents, their representatives, and families of those residing in facilities by 5PM the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42132 Based on observations, clinical record reviews, facility policy review, the Centers of Disease Prevention and Control (CDC) recommendations, Centers of Medicare and Medicaid Services (CMS) guidelines, and staff interview the facility failed to complete outbreak testing for the residents and staff for the novel Coronavirus 2019 (COVID-19) in accordance with CDC guidance for testing with the potential to affect 23 of 24 residents. The facility reported a census of 24 residents. Findings Include: The Minimum Data Set (MDS) assessment for Resident #15 dated 11/18/22, identified a BIMS of score of 15, indicating no cognitive impairment. The MDS listed diagnoses of HTN (hypertension), diabetes, and non-alzheimer's dementia. The Care Plan for Resident #15, with a target date of 12/14/22, identified the resident had a respiratory infection related to chronic disease processes, COVID positive (+) on 11/29/22, and in isolation for 5 days. The Care Plan interventions included: a. Oxygen at 1 liter/nasal cannula (L/NC) b. Activity as tolerated, to help increase lung expansion c. Emphasize good hand washing techniques to all direct care staff d. Encourage fluid intake e. Isolation precautions f. Medications/treatments as ordered by the physician g. Monitor/document level of consciousness and any changes h. Monitor/document breath sounds, rate, rhythm, and the use of any accessory muscles i. Monitor/document/report to the physician as needed for signs and symptoms of dehydration, dry skin and mucous membranes, poor skin turgor, weight loss, fatigue, hypotension, increased heart rate, fever, or abnormal electrolyte levels Observations of Resident #15's room on 12/1/22 at 9:00 AM and on 12/6/22 at 12:27 PM revealed the door closed with a sign posted directing the use of droplet isolation and to utilize the following: gown, N95 mask, gloves, hairnet, booties, and a face shield. A 3-drawer cupboard to the left of the door contained gloves, hand sanitizer, face shields, eye protection, surgical masks, and N95 masks. The Progress Notes for Resident #15 revealed the resident tested positive for COVID-19 on 11/29/22 at 1:29 PM. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities schedules and time clock punches from 11/30 - 12/5/22 revealed the following: a. On 11/30/22 (day 1 of testing) - 22 staff should have tested for COVID b. On 12/1/22 - 6 staff should have tested for COVID, who had not tested on [DATE] c. On 12/2/22 (day 3 of testing) - 15 staff should have tested for COVID d. On 12/3/22 - 5 staff should have tested for COVID e. On 12/4/22 (day 5 of testing) 6 staff should have tested for COVID f. On 12/5/22 - 14 staff should have tested for COVID Review of the facilities COVID-19 Testing Log revealed: a. On 11/30/22 - 4 staff tested b. On 12/1/22 - 5 staff tested c. On 12/2/22 - no staff tested d. On 12/3/22 - 1 staff tested e. On 12/4/22 - no staff tested f. On 12/5/22 - 7 staff tested The facility policy titled COVID-19 Protocol Phase IV revealed: a. Revised 8/26/20 instructed: 1. For outbreak testing: all residents and staff should be tested . All staff and residents that test negative should be retested every 3-7 days until testing identified no new cases of COVID-19 for a period of at least 14 days since the most recent positive results. 2. Testing of staff and residents in response to an outbreak - an outbreak is defined as a new COVID-19 infection in any health care provider (HCP) or staff. b. Updated 10/11/21 instructed: 1. Newly identified COVID-19 positive staff or resident in the facility that can identify close contacts - test all residents and staff regardless of vaccine status that had a higher risk exposed with the COVID-19 positive individual 2. Newly identified COVID-19 positive staff or resident(s) in the facility that is unable to identify close contacts - test all residents and staff regardless of vaccine status, facility wide. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 9/23/22, under the section Responding to newly identified COVID-19 infected HCP or residents: a. The approach to an outbreak investigation could involve either contact tracing or broad-based approach, however, broad-based approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact trails fails to halt transmission b. Perform testing for all residents and HCP identified as close contacts or on the affected unit if used a broad-based approach, regardless of vaccinations status. Testing recommended immediately (not earlier than 24 hours after exposure) and if negative again 48 hours after the first negative test and if negative, again 48 hours after the second negative test. Testing would typically be day 1 (day of exposure day 0), day 3 and day 5. c. Testing should be considered for those who have recovered in the prior 31-90 days d. If additional cases are identified, strong consideration should be given to shifting to a broad based approach if not already being performed and implementing quarantine for residents in the affected area of the facility. As part of the broad-based approach, testing should continue on affected unit or facility wide every 3-7 days until there are no new cases for 14 days CMS QSO-20-38-NH revised 9/23/22, a. Testing of Nursing Home Residents and Staff, Testing Summary 1. Newly identified COVID-19 positive staff or resident in the facility that can identify close contacts - test all residents and staff regardless of vaccine status that had a higher risk exposed with the COVID-19 positive individual 2. Newly identified COVID-19 positive staff or resident in the facility that is unable to identify close contacts - test all residents and staff regardless of vaccine status, facility wide b. Testing of Staff and Residents During an Outbreak Investigation 1. An outbreak investigation would be initiated when a single new case of COVID-19 occurred among residents or staff to determine if others have been exposed. In an outbreak investigation, rapid identification and isolation of new cases was critical in stopping further viral transmission. 2. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after exposure, if known) On 12/1/22 at 10:00 AM, the Interim Director of Nursing (IDON) stated the facility had one positive COVID-19 resident in the facility and the resident was in isolation precautions. The IDON stated the resident had tested positive for COVID-19 on 11/29/22. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/22 at 9:33 AM, the IDON stated the facility continued to have only one resident that had tested positive for COVID-19 and continued to be in isolation. The IDON stated no other residents had tested positive of COVID-19. The IDON stated Resident #15 had tested positive for COVID-19 on 11/29/22 and no other residents had been tested for COVID-19. The IDON stated all staff that had been tested for COVID-19 would be documented on the facility COVID-19 testing log. On 12/6/22 at 9:04 AM, Staff F, Certified Nurses Aide (CNA), stated Resident #15 tested positive for COVID-19 and the facility staff were telling each other they needed to test for COVID-19 before their next scheduled shift. Staff F stated she had not been tested due to her last day working at the facility was 11/30/22. Staff F stated the residents were not tested for COVID-19 and she was concerned. Staff F explained that she even asked the IDON. Staff F stated the IDON informed her the residents were not going to be tested , even when another resident had tested positive for COVID on 11/29/22. Staff F stated the IDON informed her it was her judgment if the residents needed to be tested for COVID-19 and that all the residents were not going to be tested for COVID-19. On 12/6/22 at 10:01 AM, Staff L, Licensed Practical Nurse (LPN), confirmed she had worked 6 AM - 6 PM on 11/29/22, 11/30/22, and 12/2/22. Staff L confirmed Resident #15 tested positive for COVID-19 on 11/29/22. Staff L stated she worked with Resident #15 on 11/29/22 and had assisted the resident to the bathroom. Staff L stated the resident had sounded congested, however, it had sounded like the resident had required increased assistance and sounded congested for a few days. Staff L stated she did not test for COVID before working her scheduled on 11/30/22. Staff L stated the facility had not tested her for COVID as of today, even with working with the resident on the 29th and 30th. Staff L stated herself and other staff members questioned not being tested for COVID-19 due to having worked with Resident #15, who tested positive for COVID-19. Staff L stated when she reported to work on 12/5/22, the facility administration had informed her that she had to wear a mask while on duty; however, Staff L stated she did not know where the requirement came to wear a mask. Staff L stated she was not aware of the CDC guidelines related to use of masks and/or testing, and felt it was the facility's job to tell the staff what to do related to testing and use of masks. On 12/6/22 at 11:18 AM Staff F, CNA, explained that when she arrived for her scheduled shift on 11/30/22 at 10 PM, she did not test for COVID-19. Staff F stated she was not required to take a COVID test due to being COVID positive at the end of August. Staff F stated she had tested for COVID on 11/28/22 and was negative. Staff F stated when the staff completed a COVID test, was to be documented on a clipboard by the back door staff entrance. Staff F confirmed she did not document that she tested for COVID and was negative. Staff F stated that when Resident #15 tested positive on 11/29/22, the evening staff informed her she needed to test, however, she did not test the following day (11/30/22). Staff F stated her days ran together due to working so many days in a row. Staff F stated she did test for COVID on the day Resident #15 had tested positive for COVID (11/29/22); however, not on 11/30/22 and she had not worked since 11/30/22. On 12/6/22 at 11:36 AM Staff M, Registered Nurse (RN), confirmed that he worked on 11/30/22 6 PM - 6 AM and did not test upon arrival to his scheduled shift at the facility. Staff M stated he had asked the IDON about masks, however, had been informed the county transmission was low and did not need to wear masks. Staff M stated no staff mentioned anything about COVID testing. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/22 at 12:24 PM Staff N, CNA, confirmed that he had worked at the facility on 12/1/22, 12/2/22, 12/4/22 and 12/6/22. Staff N stated he tested for COVID at the start of his shift on 12/2/22 and was negative. During the review of the facilities COVID-19 Testing Log, Staff N stated he did not document the negative COVID test. Staff N stated the facility had not informed him that he needed to take a COVID test at any time, that he tested on his own when he reported to work. Staff N stated he did not COVID test on 12/1/22, his first scheduled shift at the facility. On 12/6/22 at 12:28 PM Staff C, CMA, reported that she tested daily upon arrival to the facility. Staff C stated she would test and wait outside for 15 minutes before entering the facility. During a review of the facilities COVID-19 Testing log, Staff C stated she had forgotten to document her COVID test on the log. Staff C stated the testing log was located on a clipboard by the back door where the staff enter the building. Staff C stated she had always tested herself daily when arrived at work. On 12/6/22 at 12:30 PM, Staff D, CNA, stated she got tested for COVID on 12/1/22 prior to her scheduled shift. Staff D confirmed that she worked on 11/30/22 and stated that she did not get tested for COVID. Staff D stated the facility informed the staff they were to test every week, however, the facility did not care if or when the staff even tested . Staff D stated a co-worker called in on 12/3/22 due to not feeling well and had tested negative for COVID; however, the co-worker attempted to work on 12/4/22 and tested positive for COVID when tested at the facility. On 12/6/22 at 12:31 PM Staff B, CNA, stated she preferred to COVID test before every shift worked and was supposed to document the test results on the clipboard by the back door. Staff B stated no residents had been COVID tested since Resident #15 had tested positive for COVID on 11/29/22. Staff B stated the staff were only COVID tested if they tested on their own. Staff B stated the facility did not inform the staff that they were to be COVID testing. Staff B stated Staff P tested COVID positive over the weekend. On 12/6/22 at 12:33 PM, Staff G, CMA, stated she worked every day at the facility without a day off, confirming she worked daily from 11/30/22 - 12/6/22. Staff G stated she took a COVID test herself on 12/6/22 when she arrived at work due to having mild respiratory symptoms, however, she tested negative for COVID. Staff G stated she was not aware of the last time she got tested for COVID at the facility, at least a couple of months ago during the last facility outbreak. Staff G stated the facility did not require the staff or residents to take a COVID test since the last facility outbreak a couple of months ago. Staff G stated the facility has not informed any of the staff that they needed to COVID test. Staff B stated she wanted to take a COVID test to make herself feel better about working. Staff B stated the facility staff never got told to take a COVID test, even after the resident tested positive on 11/29/22. Staff G stated she had called the IDON on 12/3/22 and informed the IDON that the facility had two staff test positive for COVID with the resident who had already tested positive and the IDON stated the facility had to implement wearing of masks while at work, the IDON did not mention COVID testing. During a review of the facilities COVID-19 testing log, Staff G stated she did not document her negative COVID test. On 12/6/22 at 1:31 PM, Staff O, LPN, stated she had not worked at the facility in the last couple of weeks, however, she had not taken a COVID test upon arrival to her scheduled shift. Staff O stated she got tested on [DATE] at another facility and was negative. Staff O stated the facility did not inform her that she needed to take a COVID test due to staff and residents being COVID positive. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/22 at 1:33 PM, the IDON confirmed Resident #15 tested positive for COVID on 11/29/22. The IDON stated her first day at the facility was 10/31/22 and the staff were to be COVID tested weekly at that time. The IDON stated the residents were only tested for COVID if signs and symptoms of COVID were identified. The IDON started when a couple of residents had tested negative for COVID after reports of a cough. The IDON stated one new positive COVID from a resident or a staff member was not an outbreak. The IDON confirmed that two staff did test positive for COVID over the weekend. On 12/6/22 at 1:35 PM, the Administrator stated all the staff were COVID tested weekly before they came into the building for their scheduled shift and/or the staff tested before entry into the facility if the staff had signs or symptoms of COVID. During a review of the QSO-20-38-NH revised 9/23/22 with the Administrator regarding a COVID outbreak and testing, the Administrator stated the facility would start COVID testing all residents and staff. On 12/6/22 at 2:29 PM, Staff P, RN, confirmed that she worked at 6 AM on 12/1/22. Staff P stated she did not test for COVID upon arrival to her scheduled shift on 12/1/22. Staff P stated that she had not worked on the 11/29 or 11/30/22. Staff P stated on 12/1/22 she felt unwell while at work and as the day went on continued to feel worse, she became fatigued and had a headache. Staff P stated that by 12/2/22 she could not smell or taste and the fatigue and headache were worse. Staff P stated she had tested positive for COVID on 12/2/22 and notified the IDON on 12/3/22. Staff P stated she had never been told that she had to test for COVID at the facility prior to working. Staff P stated she was aware a resident had tested positive for COVID on 11/29/22, however, she had not been instructed that the staff had to test for COVID upon arrival for scheduled shift. Staff P stated there were staff that did their COVID test on their own who had not been instructed to test. Staff P stated the IDON never informed the staff of the need to do a COVID test after the resident had tested positive. On 12/7/22 at 8:25 AM, the IDON stated all the residents were COVID tested on [DATE] and all residents tested negative.