STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165426	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Perry	2625 Iowa Street Perry, IA 50220

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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** 50500 Based on observation, policy review, and resident and staff interviews, the facility failed to ensure staff interacted with residents in a professional manner for 1 of 4 residents reviewed (Resident #2) for resident rights. The facility reported a census of 33. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed Resident #2 with a Brief Interview for Mental Status score of 3 out of 15, indicating a severe cognitive impairment. Diagnoses listed on the MDS include stroke, hemiplegia/hemiparesis, diabetes, depression, schizophrenia, and respiratory failure. Delusional behaviors also noted. The Care Plan, with a completed date of 9/23/24, listed a focus area related to bladder incontinence. Interventions include, in part; asking/encouraging resident to utilize call light system to report need to use the bathroom. The Care Plan also listed a focus area related to Resident #2 need for staff assistance for personal cares. Interventions include, in part; at least 1 staff member to assist with bathing/showering, dressing, toilet use and surface transferring. Review of a facility self-report document, with an event date of 11/17/24, stated Resident #2 alleged verbal abuse against Staff A, Certified Nursing Assistant (CNA). The report described Resident #2 as alert and with no signs of injury. An Incident Note, dated 11/17/24 at 9:30 PM, revealed the following: Resident told this writer, she told the staff [Staff A, CNA] who answered her call light to Go get (Staff B) the staff member said she was not going to get her. and she [Resident #2] told the staff member you don't know how to help This staff asked this resident if she was ok and she said yes. A Social Services Progress Note, dated 11/18/24 at 2:52 PM, revealed the following: I followed up with resident from last night and she is calm and states that she feels better as long as she does not have to have (Staff A) - CNA work with her. I will continue to follow up. During an observation on 11/25/24 at 11:00 AM, Resident #2 received cares from two unidentified staff members in her room without difficulties. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165426	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Perry	2625 Iowa Street Perry, IA 50220

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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	During an interview on 11/25/24 at 11:40 AM, Resident #2 detailed events of the incident from 11/17/24. Staff A , CNA responded to Resident #2's call light. Resident #2 asked for Staff B, CNA instead and did not want Staff A's help. Resident #2 stated Staff A attempted to turn off the call light but Resident #2 did not want it turned off. Words were exchanged. As Staff A was leaving the room, Resident #2 heard Staff A responding back with a **** [profanity] you from the hallway. Resident #2 does not recall specifics during the conversation in the room, but stated profanity may have been used by both parties. During an interview on 11/25/24 at 12:50 PM, Staff A, CNA recalled the events of 11/17/24. At approximately 8:00 PM, Staff A responded to Resident #2's call light. Immediately upon entering the room, Resident #2 stated No, No. Go get (Staff B) with her open hand in the air. Staff A indicated she would alert the requested staff member and that the call light needed to be turned off. Resident #2 responded with No, you are an abuser. Get the ****[profanity] out. Staff A reported turning off the call light and leaving the room. Staff A stated she did not use profanity in the room or out in the hallway. During an interview on 11/25/24 at 2:30 PM, Staff C, CNA recalled the events of 11/17/24. Staff C reported sitting in Director of Nursing's office when at approximately 8:15 PM, she heard Staff A and another staff member talking. Staff A sounded upset but could not tell what it was about. Staff B then approached Staff C and informed witnessing Staff A freak out on Resident #2, which included the use of profanity. Staff C reported checking on Resident #2 after this report. Resident #2 found crying and stated that Staff A was cursing at her. By the time Staff C left the room, Resident #2 had stopped crying. During an interview on 11/25/24 at 3:00 PM, Staff B, CNA recalled the events of 11/17/24. Approximately 45 minutes prior to events, Staff B and another staff member in training were in Resident #2's room without incident. Staff B left and attended to other residents. When returned to the nurse's station, Staff B noticed two call lights on, one of which was Resident #2. As walking down the hallway to address call lights, Staff B observed Resident #2's call light turned off and heard an altercation. Staff B reported hearing Resident #2 yelling back at Staff A, CNA and believes there may have been profanity from both parties. Staff B observed Staff A leaving Resident #2's room saying don't *******[profanity] care if requested Staff B shut the **** [profanity] up. Staff B checked on Resident #2 and found her crying. Staff B reported Resident #2 was not herself for the rest of the night and cried herself to sleep. The policy Exercise of Rights/Resident Rights F 550, last revised 11/2017, stated residents have the right to be treated with respect and dignity that promotes maintenance or enhancement of his or her quality of life, recognizing each resident ' s individuality. The policy directed staff to: a. Residents shall be treated with dignity and respect b. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth c. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs