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	12/17/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46873 Based on observation, clinical record review, staff and resident interviews and facility policy review, the facility failed to implement interventions to safeguard the dignity and wishes of Resident #34 after a Resident to Resident incident between Resident #34 and Resident #18. The facility reported a census of 33. Findings include: The Minimum Data Set (MDS) Assessment of Resident #34, dated 8/12/24, identified a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented the resident experienced delusions during the 7 day look back period. The MDS documented diagnoses that included depression, bipolar disorder, psychotic disorder and schizophrenia. The MDS Assessment of Resident #18, dated 10/6/24 identified a BIMS score of 15 which indicated cognition intact. The MDS documented the resident exhibited behavioral symptoms not directed toward others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, daily during the 7-day look back period. The MDS documented diagnoses that included anxiety and depression. On 12/9/24 at 3:06 pm, Resident #34 reported she had recently been standing near the nurses desk, conversing with an employee. She stated Resident #18 was self propelling his wheelchair past her, and his arm went up her leg and then to her right buttocks. She said that he made a statement of not trying to do anything to her. She stated he touched her with his hand, and it was not a brush up with his arm. She said it made her wonder, as nobody expects anything like that to happen. On 12/9/24 at 2:56 pm, Resident #18 stated he had bumped into Resident #34. He stated it was accidental and he apologized. The Contact Form for Facility Reported Incidents revealed the date of the incident to be 12/5/24. The Social Services Progress Note in the Electronic Health Record (EHR) of Resident #34, dated 12/5/24, authored by the Director of Nursing (DON), documented Resident #34 reported Resident #18 touched her bottom and it made her feel uncomfortable. The DON documented she made all necessary notifications. The note failed to document any interventions put in place to keep Resident #34 and Resident #18 separated. (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	12/17/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services Progress Note in the EHR of Resident #18, effective date 12/6/24, created date 12/10/24 (late entry), authored by the Director of Nursing, documented Resident #18 thought he had bumped the foot of Resident #34 with his wheelchair as he was passing by. The note documented Resident #18 reported he patted her bottom to apologize and denied the touch as being sexual. The note failed to documented any interventions put in place to keep the two residents separated. The Witness Statements by three facility staff members on duty on 12/5/24 revealed statements were gathered five days later, on 12/10/24. None of the statements documented any interventions put in place to keep the two residents separated. On 12/10/24 10:54 AM, The Care Plan of Resident #18 was reviewed. The Care Plan revealed a focus area dated 10/5/24 noted alleged inappropriate behavior towards a female. It failed to reveal any documentation of interventions to keep Resident #18 and #34 separated. On 12/10/24 at 10:56 am, the Care Plan of Resident #34 was reviewed. It failed to reveal any documentation of interventions to keep Resident #34 separated from Resident #18. On 12/10/24 at 11:43 am, the DON stated no staff had directly witnessed the incident between the two residents. She stated Resident #34 had felt Resident #18 touch her bottom and it made her feel uncomfortable. The DON stated Resident #34 had initially reported this to Staff I, Certified Nurse Aide (CNA) and Staff I then brought Resident #34 to the DON office. The DON further stated Resident #18 had admitted to patting the buttocks of Resident #34 as an apology for bumping into her. She stated she believed Resident #18's intentions were not sexual. She stated Resident #34 is not always the most reliable. The DON further stated the two residents live on separate hallways. She stated the incident happened on a Thursday and she followed up with Resident #34 the next Monday. She said Resident #34 reported no further concerns. She added the two residents do not eat at the same table or attend the same activities. She stated the care plans had not been updated for either resident as the facility was still in the window for submitting a five day follow up on the incident. She stated she would update the care plans of both residents for staff to monitor the two residents to make sure they are kept apart. She said staff that were on duty on 12/5/24 did receive education but no further staff received any education at that time. On 12/10/24 at 11:52 am, the State Surveyor was standing at the nursing desk waiting for Staff G, Licensed Practical Nurse (LPN) to complete a phone call. The State Surveyor observed the DON and Staff I, CNA speaking privately in the dining room. On 12/10/24 at 11:55 am, Staff G, LPN stated when Resident #34 told her concerns to Staff I, CNA, Resident #34 was then taken to the DON office to notify her. She stated the facility has an abuse hotline flyer at the nursing station. She stated no direction was given to her to keep the residents separated but she stated she would consider that a given to do in this situation and kept an eye on the residents. (continued on next page)

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	12/17/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 12:01 pm, Staff I, CNA stated she was sitting at the nurses station charting on 12/5/24 when Resident #34 came to her and told her Resident #18 had went past her in his wheelchair and had groped her behind. She stated she told Resident #34 she needed to report this to the DON and she took Resident #34 to the DON office. She stated the DON told her to keep the residents separated and to check on the residents every 15 minutes. She stated the 15 minute checks were to be completed every 15 minutes. On 12/10/24 at 12:08 pm, Staff J, CNA stated she did know have any information on the interaction between Resident #18 and Resident #34. She stated she did not witness anything. She further stated she received no education regarding the two residents and nobody asked her to watch the two of them. On 12/10/24 at 12:09 pm, Staff A, Certified Medication Aide (CMA) stated he came on duty at 2:00 pm on 12/5/24. He stated he had no knowledge of any incident between the two residents and nobody at the facility had said anything to him about it. He was unaware of any incident prior to the State Surveyor asking him. On 12/10/24 at 12:49 pm, Resident #34 was observed sitting at the far end of the dining room, near the exit to the patio. Staff J, CNA, stated that was not the resident's normal place to sit in the dining room. On 12/10/24 at 12:55 pm, Resident #34 stated she was sitting in at a different table because a different resident was sitting in her normal spot when she arrived to the dining room. When asked about how she was feeling regarding Resident #18, Resident #34 replied she felt scared because she felt it could happen again because Resident #18 knew what he was doing. In a follow up interview on 12/10/24 at 1:00 pm, Resident #18 stated the facility staff asked him what had happened during the incident and he told them. He stated he said he was sorry and the facility staff said ok. He denied receiving any direction or requests to keep distance from Resident #34. The Care Plan of Resident #18 was updated on 12/10/24 by the DON to keep Resident #18 and Resident #34 separated as much as possible. It directed staff to not sit the two residents together in the dining room or at activities. It additionally directed staff to attempt to keep Resident #18 from going down Resident #34's hallway as much as possible. The Care Plan of Resident #34 was updated on 12/10/24 by the DON. A revision was made to the Focus Area of risk for behavior problems indicating an incident of reporting to staff a male resident touching her on her bottom. It directed staff to keep Resident #34 and Resident #18 away from each other as much as possible, to not have them next to each other in dining room or activities. It additionally directed staff to discourage Resident #34 from being near Resident #18. The Facility Policy Resident-to-Resident Altercations F600, revision date 10/2022 documented the following: Point 2: a. Separate the residents, and institute measures to calm the situation; (continued on next page)

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	12/17/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation; c. Provide and document re-direction and provide protection as required by the situation d. Notify each resident's representative and Attending Physician of the incident; e. Review the events with the Nursing Supervisor and Director of Nursing, including interventions to try to prevent additional incidents; f. Consult with the Attending Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem; g. Make any necessary changes in the care plan approaches to any or all of the involved individuals h. document in the resident's clinical record all interventions and their effectiveness;

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	12/17/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41537 Based on record review, staff interview, and policy review the facility failed to implement safety interventions for vaping (a mechanical device used for inhaling vapor containing nicotine and flavoring) for 1 of 1 residents who vapes at the facility (Residents #21). The facility also failed to ensure 1 of 1 residents who leaves for appointments had appropriate caregivers with her (Resident #8). The facility reported a census of 33 residents. Findings include: 1. During an interview on 12/09/24 at 9:29 AM with the Administrator revealed Resident #21 will occasionally vape. Record review of Resident #21 Assessments in her Electronic Health Record (EHR) on 12/11/24 lacked nursing assessment of her vaping. During an interview on 12/12/24 at 12:44 PM with the Director of Nursing (DON) revealed she would expect Resident #21 to have a smoking assessment completed and implement appropriate safety interventions as needed. Review of the facilities policy, Accident Prevention - Smoking Policy, effective 8/2024 instructed staff of the following: Residents whom wish to smoke will be evaluated for safe smoking per community protocol. 2. During an interview on 12/09/24 at 1:42 PM with Resident #8 Power of Attorney (POA) revealed on 12/3/24 resident #8 left the facility for a Cardiologist appointment on a bus unaccompanied by facility staff. She revealed she arrived to Resident #8 appointment shortly after she was dropped off by the bus and found her needing assistance to get checked in, as she is unable to do by herself. During an interview on 12/12/24 at 12:44 PM with the DON revealed she would expect incompetent residents be assisted to appointments.