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	06/03/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, staff interviews, and policy review the facility failed to ensure a cognitively impaired resident's environment remained free of hazards. The facility further failed to ensure the resident received the appropriate consistency of food, which led to the resident choking and as a result dying. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of May 23, 2025 on May 29, 2025 at 10:50 AM. The Facility Staff removed the Immediate Jeopardy on May 29, 2025 through the following actions: 1. CPR audit conducted with 100% nurse compliance and several additional CNA/CMA staff members certified 5/23/25. 2. Diet modification audit conducted to ensure proper diet orders for all residents 5/23/25. 3. Dietary staff meeting called to discuss types of modified diets, how to determine proper texture, resident behaviors during meals times, and staff meal procedures 5/23/25. 4. All-staff education provided regarding types/importance of modified diets, how to determine proper texture, resident behaviors during meals times, staff meal procedures, and review of Heimlich maneuver 5/29/25. 5. Code status audit conducted for all residents to ensure advanced directives are reflected accurately in the chart 5/25/25. BLS CPR class will be offered to all interested staff on 5/31/25. 6. Management daily audit of meal consistency audit conducted for a random mealtime x7 days 5/23/25. 7. All-staff training provided: staff personal food and drink must be stored and consumed in designated staff areas and not in resident living areas 5/29/25. The scope was lowered from a J to a D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility reported a census of 31 residents. Findings include: (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

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Electronic Healthcare Record (EHR) page titled assessments revealed a Brief Interview for Mental Status (BIMS) assessment completed 5/22/25 documented a score of 99 indicating a BIMS assessment was unable to be completed as the resident is rarely/never understood. This assessment further revealed an admission date of 5/19/25. The EHR page titled, Medical Diagnosis, revealed diagnosis of autism, PICA (an eating disorder characterized by the persistent craving and consumption of non-nutritive, non-food substances) in adults, severe intellectual disabilities, and schizoaffective disorder. The Baseline Care Plan dated 5/19/25 revealed Resident #1 required one person physical assistance with eating. The Care Plan revealed Resident #1 was on a regular mechanical soft diet with ground meat. The Care Plan revealed that Resident #1 required visual supervision for all cares. The Care Plan documented his code status as Do Not Resuscitate (DNR), comfort measures only and to allow a natural death. The initial goals listed on the Care Plan were to ensure safety and maintain ADL's for a long term stay. The Care Plan documented the resident liked to put his hands in his mouth and was at risk for chewing problems. It also documented he needed monitoring at all times. The Progress Notes for Resident #1 documented the following: On 5/23/25 at 4:06 PM Staff A walking resident when Administrator joined her. Resident walking through dining room attempting to grab meals so they decided to take him to his room. Kitchen staff delivered his room tray. Staff observed an extra plate had been delivered of regular pizza for Staff A to the resident's room. It was immediately moved to the other end of the dining table in his room. The Administrator thought it was out of his reach. The resident took bites of his food and drank fluids without difficulty. Resident #1 then impulsively stood up from his chair, pushed the table forward with his lower body, lunged across the table past both staff members (Staff A, and the Administrator) and grabbed the regular pizza, wadded the pizza in his right hand and immediately shoved the entire piece of pizza in his mouth. After a couple seconds Resident #1's lips began to turn blue, the Administrator began the Heimlich Maneuver and Staff A called 911. The resident started coughing and spit some of the pizza out of his mouth and started breathing. The resident continued to have food lodged in his throat, resident was conscious at this time. Residents breathing noted to be abnormal, gasping for air, Heimlich Maneuver was continued. An officer arrived on the scene and took over with the Heimlich maneuver. Staff A attempting to open residents mouth however resident was gritting his teeth together which kept his mouth closed preventing any food from exiting his mouth. Heimlich maneuver continued until the resident collapsed. Resident laid on the floor and the officer started Cardiopulmonary Resuscitation (CPR) per choking protocol. The Administrator confirmed on the phone with the Director of Nursing (DON) the resident was a DNR. This was confirmed via phone call with the mother. The mother told the staff to stop CPR once the resident was confirmed to not have a heart beat and was not breathing. All life sustaining support stopped by Emergency Medical Service (EMS). Resident pronounced deceased by EMS and the County Medical Examiner called. The County Medical Examiner stated death accidental with no foul play suspected however the Provider did want the resident's body sent for an autopsy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview 5/28/25 at 1:05 PM with Staff A Certified Medication Aide (CMA) revealed it was the first day taking care of Resident #1. Staff A further revealed that Resident #1 Went to breakfast around 8:30 AM, and other staff was teaching her what to do and not to do since she hadn't worked with Resident #1. Staff A then revealed Resident #1 was trying to take other residents' food in the dining room. Staff A revealed that the Administrator and herself took Resident #1 to his room to eat. Staff then revealed she had asked Staff B Dietary Aide and Staff C Dietary Aide if they could get more food for Resident #1 and to save her a slice of pizza. Staff A revealed that the Administrator and herself were assisting Resident #1 in the bathroom when Staff C delivered Resident #1's mechanical diet along with her slice of pizza. Staff A revealed she had noticed the regular pizza so she immediately placed it on the opposite side of the table in Resident #1's room. Staff A revealed that Resident #1 pushed the table, and quickly grabbed the pizza at the other end of the table and shoved it all into his mouth, hand and all. Staff A further revealed that Resident #1 also had a diagnosis of PICA. Staff A revealed that she did not ask dietary staff to bring her pizza into Resident #1's room as staff are not supposed to eat when assisting with feeding residents, and staff are not supposed to eat in the residents' rooms or dining room. Staff A further revealed that the Administrator attempted abdominal thrusts while she called 911 right away. Staff A revealed a police officer came to the facility and attempted abdominal thrusts on Resident #1. Staff then revealed Resident #1 was breathing, but still had food in his mouth and would not open his mouth while clinching his teeth. Staff A revealed that Resident #1 was gasping at this time. Staff A further revealed that abdominal thrusts were continued until Resident #1 collapsed and then the police officer started CPR until it was revealed that Resident #1 had an order for do not resuscitate (DNR) at which point it was confirmed and Resident #1 passed away. Interview 5/28/25 at 1:33 PM with Staff B revealed he did not deliver food to Resident #1's room and that Staff C had delivered the food to the room. Staff B then revealed that Resident #1 was on a mechanical soft diet and could have finger foods. Staff B further revealed he had observed Resident #1 attempt to grab things, but did not witness it a lot as he was working in the kitchen. Interview 5/28/25 at 1:40 PM with Staff C revealed that she did deliver the food to the room for Resident #1 per staff request. Staff C revealed that she brought a mechanical diet for Resident #1 and on a separate plate had a regular piece of pizza for the staff. Staff C revealed that when the food was delivered the staff were assisting Resident #1 in the bathroom so she left the food tray on the table and left the room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview 5/28/25 at 2:00 PM with the Administrator revealed she had gotten to the facility early and was providing help to staff who was providing 1 to 1 support for Resident #1 during waking hours related to his autism. The Administrator then revealed Resident #1 was in the dining room, and was trying to grab other residents' food. The Administrator revealed Staff A and herself decided to send food to Resident #1's room. The Administrator revealed Staff A did ask staff to save her a piece of pizza. The Administrator revealed Staff A and herself helped Resident #1 to the bathroom, and when they came out the food was on a tray on the table. The Administrator then revealed that Staff A escorted Resident #1 to a small table in the resident's room where the food tray was. The Administrator revealed Resident #1 was sat at one side of the table, Staff A was at the corner closest to Resident #1. The Administrator further revealed she was standing next to Staff A on the same side of the table. The Administrator revealed that Staff A's regular slice of pizza was placed on the opposite side of the table furthest away from Resident #1. The Administrator then revealed that staff do not eat in residents' rooms and she was going to relieve Staff A for lunch and Staff A could take her pizza after assisting the resident in his room with his meal. The Administrator then revealed Resident #1 stood up fast and pushed the table with his groin and grabbed the slice of regular pizza and shoved the entire piece into his mouth hand and all. The Administrator revealed that Staff A immediately pulled the Resident #1's hand out of his mouth, and noticed that the resident's lips were turning blue. The Administrator revealed that she initiated the abdominal thrusts as Staff A called 911, and pulled the call light. The Administrator further revealed that Resident #1 was having abnormal breathing and abdominal thrusts were continued. The Administrator revealed that Resident #1 was shaking his head and gritting his teeth as to not let the food come out and was chewing. The Administrator then revealed police had arrived and continued abdominal thrusts until Resident #1 collapsed. The Administrator revealed the officer then initiated CPR per the choking policy and the Administrator called the Power of Attorney (POA) and confirmed that Resident #1 was a DNR to which the POA revealed to let Resident #1 pass. Interview 5/28/25 at 3:15 PM with Staff D Social Services Director (SSD) revealed that she had witnessed Resident #1 attempt to take other residents' items. Staff D revealed at meals the staff would take Resident #1 outside for a walk, and or take him to his room. Staff D further revealed due to Resident #1's PICA diagnosis he would try to take any item and put it in his mouth. Staff D revealed that when she worked with Resident #1 she would not eat in his room, and revealed that staff are not supposed to eat in residents rooms or in the dining room when they are assisting to feed. Staff D then revealed the pizza that was placed into Resident #1's room should not have been there. Interview 5/28/25 at 3:30 PM with Staff E Certified Nursing Assistant (CNA) revealed that he never ate around Resident #1. Staff E further revealed that food should not be in the residents' rooms as the attention should be on the residents' and not eating. Interview 5/28/25 at 3:48 PM with the DON revealed she was not at the facility when Resident #1 had the choking incident. The DON further revealed she had witnessed Resident #1 attempt to take other residents' food. The DON revealed when Resident #1 would attempt to take other residents' food in the dining room area staff would try to redirect Resident #1, and if that redirection did not work then staff would redirect Resident #1 to his room to eat. The DON further revealed Resident #1 was on a mechanical soft diet with ground meat. The DON then revealed staff are not allowed to eat around the resident or in his room. The DON revealed the pizza should have not been in the residents room, and should have been in the break room. The DON then revealed that the pizza should have been taken out of Resident #1's room right away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview 5/29/25 at 7:40 AM with Staff F Register Nurse (RN) revealed he had witnessed Resident #1 several times attempting to take other residents' food in the dining room. Staff F then revealed that staff would try to redirect the resident, and if that would not work the staff would redirect the resident to his bedroom to eat. Staff F further revealed that Resident #1 was on a mechanical soft diet related to Resident #1 being a risk for aspiration. Staff then revealed that staff are not supposed to eat around residents who require assistance with eating, but unfortunately it has happened. Follow up interview 5/29/25 at 7:50 AM with Staff C revealed the incident happened around 9:00 AM. Staff C then confirmed that the resident #1 was a mechanical diet. Interview 5/29/25 at 8:10 AM with the County Medical Examiner revealed his office was called for an unexpected death at the facility. The Examiner revealed his assumption was Resident #1 had food bolus asphyxiation. The Examiner revealed the original 911 call was for a resident choking and police got there roughly about the time Resident #1 collapsed. The Examiner further revealed two staff were feeding Resident #1. The Examiner confirmed the original 911 call was at 9:04 AM with the first police officer arriving at 9:07 AM. The Examiner then revealed a second officer arrived at 9:27 AM. The Examiner revealed that nursing staff were trying to complete abdominal thrust, and was trying to do finger sweeps but Resident #1's jaw was clinched. The Examiner revealed staff continued abdominal thrusts. The Examiner revealed that two staff were feeding Resident #1, and told the Examiner that Resident #1 was fast and could put his whole hand in his mouth. He grabbed a whole slice of pizza, and shoved the whole thing in his mouth and was choking on it. Interview 5/29/25 at 9:03 AM with Staff G CNA revealed Resident #1 was on a mechanical diet. Staff G further revealed she had witnessed Resident #1 attempt and take other residents' food. Staff G revealed staff would then redirect Resident #1, and try to keep Resident #1 from eating other residents' food. Staff G further revealed staff were never allowed to eat in the resident rooms. Staff G revealed she would never eat around Resident #1 as Resident #1 had quick hands. Follow up interview 5/29/25 at 9:50 AM Staff A CMA revealed the incident happened around 8:40 to 9:00 AM. Staff A further revealed she had witnessed Resident #1 attempt and take food from other residents. Staff A then revealed she was trained on Resident #1 having a mechanical soft diet (chopped up). Staff A revealed the regular slice of pizza Resident #1 took during the incident was triangle shaped. Staff A then revealed there are new people working at the facility, and dietary must have forgotten. Staff A further revealed staff food is not allowed in residents rooms, and if she could have done something different she would have moved the pizza across the room or would have taken the pizza to the breakroom. Interview 6/2/25 at 4:50 PM with the State Medical Examiner's office revealed that Resident #1's cause of death was food bolus asphyxia, and the preliminary manner was accidental. Review of a facility provided policy titled, Therapeutic Diets with a revision date of 10/2024 revealed: -Definition of Mechanically Altered Diet means one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physicians or delegated registered or licensed dietician order. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Mechanically altered diets, as well as modified for medical or nutritional needs, will be considered therapeutic diets. -The Food Service Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered. -Residents on therapeutic diets will not receive extra or reduced portions or modifications that are not part of the diet, unless approved by the Attending Physician in conjunction with the Clinical Dietician. -Any snacks provided must be compatible with the therapeutic diet.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, menu review, staff interviews, and policy review, the facility failed to serve the appropriate portions for five (5) residents (#3, #9, #10, #12, and #13) who received pureed diets. The facility reported a census of 29 residents. Findings include: On 6/30/25 at 12:10 pm, Staff A, cook and the Certified Dietary Manager (CDM) indicated the facility had five (5) pureed diets to prepare. The CDM stated one was to accommodate a resident who recently had a dental procedure. Staff A placed 5 servings of fish and two unmeasured amounts of mayonnaise into the blender and pureed them. He added an unmeasured amount of hot water and blended the contents. Staff A spooned the contents into a steam pan, covered it, and placed it in the oven. He did not measure the total volume. At 12:23 PM, Staff A placed 5 rolls and two unmeasured amounts of butter into the blender and pureed them. He added unmeasured amounts of hot water and blended the contents. He spooned the contents into a steam pan and covered it. He did not measure the total volume. At 12:32 PM, staff A pureed five 4-ounce servings of coleslaw and spooned it into a steam pan. He did not measure the total volume. At 12:40 pm, the CDM used a gray handled, 4-oz disher and spooned the coleslaw into 5 bowls. The last bowl contained noticeably less coleslaw. She scooped the pureed fish into the compartmented plates but ran out before the 5th plate serving. At 2:10 pm, Staff A stated he used the menu serving chart to determine which disher to use for pureed diet serving sizes. He stated he was not familiar with and hadn't been shown the volume method (a formula which measures the final volume of pureed food divided by the number of servings to identify the correct pureed serving size). The Order Listing Report (resident diet list) confirmed the CDM's statement of residents who received pureed diets. At 2:11 pm, the CDM stated Staff A should have used the volume method to determine pureed diet serving sizes. An undated policy titled Pureed Food Preparation directed staff to portion out the number of pureed items needed to prepare pureed meals for all residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to use sanitary methods during food service to residents. Staff failed to cover facial hair, touched food and food surface area with bare hands and transported uncovered food to seven (7) residents' rooms. The facility reported a census of 29. Findings include: On 6/30/25 at 11:35 AM, Staff A, Cook, was observed in the kitchen cooking corn without a beard covering. He stated he had been employed for 3 ½ months and received orientation that included the use of hairnets and beard covering. He pointed to the policy on the refrigerator that instructed staff to wear hair and beard covering while in the kitchen. He stated he didn't have a beard cover on because he didn't know he needed one. At 11:43 AM, the Certified Dietary Manager (CDM) stated staff should be wearing facial hair covering at all times while in the kitchen. At 12:37 AM, during a continuous meal service observation, Staff A grabbed resident bowls with bare hands and his thumb came in direct contact with the food surface area of the bowls. He also put five (5) compartmented plates on the counter, placed his bare fingers on the food surface area, and repositioned them. At 12:52 AM, the CDM scooped pureed bread into a bowl for Resident #4 and placed it on the service cart. Her right thumb came in direct contact with the pureed bread. At 1:27 PM, Staff B, dietary aide (DA) transported lunch trays to 3 residents on the [NAME] hall. The coleslaw, peach cobbler, and drinks were not covered during transport. At 1:34 PM, Staff B transported lunch trays to 2 residents on the East hall. The coleslaw, peach cobbler, and drinks were not covered during transport. At 1:41 PM, Staff B transported lunch trays to 2 other residents on the East hall. The coleslaw, peach cobbler, and drinks were not covered during transport. At 2:11 PM, the CDM stated all food and drinks should be covered when transported to residents' rooms. She also stated that no non-food items should come in contact with food or the food surface area of dishes. A policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices last approved 10/2024 indicated hair nets and/or chef caps and/or beard restraints must be worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. It also directed staff to wash hands before coming in contact with any food surface area. It further indicated contact between food and bare (ungloved) hands is prohibited. A policy titled Food Preparation and Service revised 10/2024 indicated food is covered during transportation and distribution to residents.