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	10/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, resident interview and facility policy review, the facility failed to self report an incident between two residents to the State Agency for 2 out of 2 residents reviewed (Resident #10 and Resident #11). The facility reported a census of 32 residents. Findings include:1) The Minimum Data Set (MDS) dated [DATE] for Resident #11 documented a Brief Interview for Mental Status (BIMS) score of 5 indicating cognitive impairment. The MDS documented no behaviors. The MDS documented a diagnosis of Alzheimer's Disease. Interview on 10/14/25 at 10:45 a.m. with Resident #5 revealed she witnessed Resident #10 and Resident #11 have an altercation in the dining room. Resident #5 stated that Resident #11 called Resident #10 a retard and then Resident #10 reached and pulled Resident #11's hair. Resident #5 stated that she asked the staff members to intervene. Resident #5 stated that after that Resident #11 went to sit by her. Resident #5 stated that she reported this to Staff A, Social Worker. Interview on 10/14/25 at 11:30 a.m. with Staff A stated that Resident #5 reported to her that Resident #10 pulled Resident #11's hair. Staff A stated that she didn't witness this incident. Staff A stated she called and reported this to the Administrator. Staff A stated that this incident happened around supper time. 2) The Minimum Data Set (MDS) dated [DATE] for Resident #10 documented a Brief Interview for Mental Status score of 15 indicating intact cognition. The MDS documented no behaviors.Interview on 10/14/25 at 1:00 p.m. with the Administrator, stated she received a phone call from Staff A around supper time, stating Resident #5 reported that Resident #10 grabbed Resident #11's hair to get her attention. The Administrator stated she asked Staff A how Resident #5 reported it to her and Staff A stated that Resident #5 was laughing about it. The Administrator asked Staff A how Resident #10 and Resident #11 were, Staff A stated they were fine. The Administrator stated that she interviewed Resident #10 and Resident #11 and neither could remember the incident or had knowledge of what happened. The Administrator stated that she is unsure if Resident #10 grabbed Resident #11's hair or put her hand through it to get her attention. The Administrator stated that she made a couple calls to the staff on the floor and they didn't have any knowledge of the incident between the two residents. The Administrator stated that she was going to interview Resident #5, but she had been having fluctuations in her anxiety and didn't want to get her anxiety worked up. The Administrator stated that Resident #5 is someone that keeps her abreast of everything that is going on in the dining room from residents to staff.Per the facility policy with an effective date of 8/2025 titled F607 F609 Abuse Program:Training, Reporting and Response, Covered Individual Responsibilities stated the policy is upon hire and annually, covered individuals will be notified of their obligations to report suspicion of crimes per above. The facility, through the Administrator or their designee, will report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property the results of all investigations to the proper authorities within prescribed time frames.Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, abuse, including injuries of unknown source, and misappropriation of resident property.Should a suspected violation or a reasonable suspicion or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse, or suspected crimes, or suspected evidence of humiliating or demeaning photographs or recordings), all covered individuals have the responsibility to report such immediately to the facility Administrator, or his/her designee in their absence. Any covered individuals are free to report directly to law enforcement and or the state agency.

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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 - 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. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy review, the facility failed to provide adequate nursing supervision to prevent elopement for 1 of 1 residents reviewed (Resident #1). Resident #1's fall risk assessment identified the resident at high risk for falls due to taking psychotropic medications. Resident #1 eloped from the facility on 7/19/25. The facility reported a total census of 32 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of traumatic brain injury, psychotic disorder, schizophrenia and bipolar disorder. The MDS showed the Brief Interview for Mental Status (BIMS) scored a 15 indicating intact cognition. The MDS showed Resident #1 ambulates and transfers independently. The Care Plan with a cancellation date of 8/1/25 showed Resident #1 transferred and ambulated independently without adaptive devices. Review of Elopement Evaluation on 5/29/25 revealed Resident #1 was not at risk of elopement. Score: 0.0Review of Resident #1's progress notes on 7/5/25 at 11:30 p.m. revealed Resident #1 attempted to go out the front door following a CNA. This was witnessed by staff, that Resident #1 did go out the door, but was followed by a staff member. The alarm did go off. Resident #1 did return to the facility. Review of Resident #1's progress notes on 7/6/25 at 1:47 p.m. revealed Resident #1 went out the side door of the building then went out the front door. Resident #1 stated she wants to go to Nebraska due to missing family. Staff was able to witness Resident #1 going out of the building and assisted her back into the building. Review of Resident #1's progress notes on 7/19/25 at 3:20 a.m.revealed Resident #1 was at the nurses station demanding a cigarette and insisted that this nurse, Staff D, Registered Nurse (RN) give her one. Resident #1 demanded a cigarette, when she was told she didn't have any left, Resident #1 became combative with the certified nursing assistant (CNA), Staff C, and attempted to leave the building several times. Staff C blocked the door to try to keep Resident #1 in the facility. Resident #1 went out the door to the south east patio. Staff D went to help Staff C, after assisting another resident but the resident wasn't found on the patio. The perimeter of the building was searched by this nurse and Resident #1 was not found. The Administrator and Director of Nursing (DON) were called several times by this nurse and CNA, but no answer. The CNA called and left a message with the Administrator with no response. 911 was then called at 3:30 a.m. by this nurse and gave an update on the situation. At 3:40 a.m., the County Sheriff was here and given an update.On 7/19/25 at 5:27 a.m. Police notified Staff C that Resident #1 was found in someone's home. The Police told Staff C that they will do their part and reach out to the facility for the next steps to take. Review of the Police Report dated 7/19/25 at 3:33 a.m revealed Staff D called in and stated Resient #1 ran away from the facility. Staff D gave a description of white female, curly short hair, wearing pajamas and no shoes. Staff D also stated the female had schizoaffective disorder. Officers responded. After searching for a while, another officer arrived with a drone to assist, while the drone was being deployed, the officers received a call stating that Resident #1 was inside her house. Officers responded and located Resident #1. Emergency Medical Services were dispatched and transported Resident #1 to the hospital. After arriving at the hospital Resident #1 agreed to go back to the facility. The hospital will contact the facility when it is time to release Resident #1. On 10/9/25 at 11:08 a.m. interview with Staff C, stated that at night sometimes people do not come in to work. Staff C stated that it was only her and the nurse that night. Staff C stated Staff D had never worked the overnight shift before. Staff C stated Resident #1 had been throwing a big nicotine fit because she had no cigarettes. Staff C stated Resident #1 kept trying to leave the facility. Staff C stated Resident #1 would not listen and kept saying I know there's a store around here. Staff C stated we tried to get her to calm down. Staff C stated we tried to get her to calm down, we tried to get her to color, watch TV and go back to her room, we tried to reassure and redirect her. Resident #1 refused to do all those things. Resident #1 wanted us to give her cigarettes and we explained that we don't smoke so we had no cigarettes. Staff C stated that another resident needed her assistant, she stated that she went to help that resident and realized that she was going to need the nurse's help also. Staff C stated that when she went to go get Staff D's assistance, Resident #1 was sitting at the dining room table, next to the south east patio door. Staff C stated that when Staff D was done assisting her, he left the room. Staff C stated that she assumed he went back out to the dining room. Staff C stated that when she was finished, she went back out into the dining room and Resident #1 was not sitting at the table. Staff C had asked Staff D where Resident #1 was at and Staff D stated I think she went back to her room. Staff C stated when they checked her room she was not in her room, so they came back out to the dining room and she