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	03/24/2026

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	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on staff interviews, resident interviews, facility document review and clinical record review, the facility failed to provide care for 3 of 7 residents reviewed (Resident #1, #2, #7) in a manner to promote dignity and respect. The facility reported a census of 34 residents.Findings include: 1. The Minimum Data Set (MDS) for Resident #1 dated 2/11/26 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.On 3/16/26 at 2:49 PM, Resident #1 reported the Administrator used profanity all the time out in the open, in front of the residents. She said there have been grievances filed related to this and the grievances went to the Administrator's boss. She said the Administrator's swearing was talked about again on Tuesday at the resident council meeting. She said the Administrator was very loud and used swear words in her everyday sentences. 2. The MDS for Resident #2 dated 2/12/26 identified a BIMS score of 15, indicating intact cognition.On 3/17/26 at 9:36 AM, Resident #2 reported the Administrator had a mouth on her and she would use the F bomb when talking. She said she called another resident a poor bastard in the dining room and she overheard her say it. She said the resident was in his room. She said the Administrator would demean residents and staff.3. The MDS for Resident #7 dated 12/17/25 identified a BIMS score of 15, indicating intact cognition.On 3/17/26 at 10:28 AM, Resident #7 said the Administrator talked loud, distracted her and she would hear the Administrator swear in everyday talk. She said she hoped the Administrator would not come back. Review of Resident Grievance/Complaint Forms dated 2/11/26 filed by the Resident Council documented concerns the Administrator and the previous DON were cussing loudly in the dining room and the Administrator had called a resident a bastard. The grievance form indicated the comment the Administrator made was about her husband being a poor bastard and not a resident. The grievance forms documented the Director of Operations completed verbal discipline with the Administrator on 2/18/26 addressing professional conduct and verbal expressions. A Witness Statement Form dated 3/16/26 completed by the Assistant Director of Nursing (ADON) documented the Administrator on many occasions has been very loud with the use of profanity to residents and staff. The ADON documented she did not feel the Administrator had verbally abused anyone directly, but had caused a tense atmosphere between staff and residents. On 3/18/26 at 8:42 AM, the Social Services Director reported she had concerns with the Administrator regarding professionalism. The Social Services Director said she did not think an Administrator should walk through the building cussing and yelling. She said she has seen the previous Director of Nursing and Administrator yelling and cussing at each other, in open areas, where residents could hear them. On 3/19/26 at 10:00 AM, the Administrator reported she was off work for allegations of verbal abuse. She said she knew there was a resident council meeting and things were said about her. She said her boss has asked her some questions. The Administrator reported she has been unprofessional from time to time and has used profanity around the residents but it was not directed at them. She said she liked to banter with some of the residents. She said she has never been inappropriate or hurt anyone's feelings. She said the population of the residents are younger and they like to have fun. She said the banter was not sinister, negative or demeaning. She reported some of the staff members would cuss when working and it was something that they all needed to work on. When asked if it was okay for (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	staff to use profanity, she said it was not okay but people slip up sometimes but that it was not directed at the residents. When asked if she has used the F word in front of the residents, she said she can't say she never has but it was not routine. The Administrator reported she was not the most professional person and she was sorry if she had offended any of the residents.On 3/23/26 at 2:17 PM, the ADON reported she had concerns with the Administrator and previous DON being loud and using profanity. She said the Administrator and previous DON would both swear in front of the resident using the F word. She said the swearing was not directly at the residents, the swearing was in conversation to each other. She said sometimes swearing was directed at the staff and residents could hear it. She said there was a grievance filed in the resident council meeting regarding the swearing. The ADON said Resident #1 reported to her that she thought the Administrator was a bully, talked down to people and made people feel small. She said Resident #1 felt uncomfortable and wanted it to be addressed but reported no concerns regarding abuse. She said the Administrator would use the facility culture as defense for using profanity because of the types of residents that lived at the facility. The ADON stated she expected the residents to be treated with dignity and respect in a professional manner. The facility policy titled Dignity revised October 2025 documented residents are to be treated with dignity and respect at all times. Each resident to be cared for in a manner that promotes and enhances individuality, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on resident interviews, staff interviews, clinical record review, facility documentation and policy review, the facility failed to facilitate the residents receiving unopened mail delivered to the facility for 2 of 7 (Resident #9 and #2) residents reviewed The facility reported a census of 34 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #9 dated 1/21/26 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.On 3/17/26 at 8:30 AM, Resident #9 reported the Administrator gives her the mail after it has been opened. She reported every time she gets something from the social security office, the mail has been opened and has been gone through. Resident #9 reported they talked about the concern in the resident council group. She said getting her mail opened made her irritated. She said she wanted to see what was going on before the Administrator saw it. She said she felt her privacy had been violated with her mail being open since it was her personal information.The facility admission Packet exhibit 5 Selection of Resident Preference initiated on 5/9/25 documented all in coming mail to be directed to Resident #9. Resident #9's Care Plan with a target date of 6/29/26 did not address mail preferences or requests for the mail to be opened by staff. 2. The MDS for Resident #2 dated 2/12/26 identified a BIMS score of 15, indicating intact cognition.On 3/17/26 at 9:36 AM, Resident #2 reported the Administrator opened all of her mail before it was delivered. She said the Administrator would tell her most of her mail was junk because she had opened it. Resident #2 said her mail being opened was a federal offense and made her feel violated. A facility form titled Mail Release dated 4/19/19 documented Resident #2 gave permission for the staff to deliver unopened personal and business mail. Resident #2's Care Plan with a target date of 5/13/26 did not address mail preferences or requests for the mail to be opened by staff. On 3/18/26 at 8:42 AM, the Social Services Director reported the Administrator would open mail for residents. She said she asked the Administrator about opening up the mail and the Administrator told her that she would open up the mail for only the residents the facility was representative payee for. The Social Worker reported she did not know how legal that was. She said she was taught to ask the resident if they would like the staff to open the mail and if they said no, let them know you could help if needed. On 3/19/26 at 10:00 AM, the Administrator reported if the facility was a representative payee for the resident, she would open up their business mail. She said she did not open up their personal mail. She said being a representative payee for the majority of the residents she was financially responsible for paying the resident's bills. She said she was not aware of what was in the facility policy.On 3/19/26 at 1:40 PM, the Social Worker reported the facility was not Resident #9's representative payee at this time and it started next month in April. The facility policy titled Mail and Electronic Communication revised May 2017 documented residents are allowed to communicate privately with individuals of their choice and may send and receive personal mail, email, and other electronic forms of communication confidentially. The policy directed mail to be delivered to the resident unopened. Staff members of the facility will not open mail for residents unless the resident requests them to do so and such requests would be documented in the resident's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review, resident interview, staff interviews and policy review the facility failed to provide bathing assistance for 1 of 5 residents reviewed for bathing (Residents #2). The facility reported a census of 34 residents.Findings include: The Minimum Data Set (MDS) for Resident #2 dated 2/12/26 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #2 required partial/moderate assistance for bathing and supervision/touching assistance for tub/shower transfer. Resident #2's MDS included diagnoses of hypertension, difficulty walking, anxiety, depression, schizophrenia and bipolar disorder. The Care Plan with a target date 5/13/26 documented Resident #2 required the assistance of one staff member with washing, rinsing, drying and dressing for showers. The care plan documented Resident #2 preferred showers scheduled two times per week and as needed (PRN). The facility paper form titled Resident Shower Schedule documented Resident #2 was scheduled for showers on the 6-2 shift on Tuesday, Thursday and Saturday. The form documented to initial or mark when the shower was completed. In addition, the form documented a shower was not completed until a shower skin assessment was handed into the charge nurse. Review of the Skin Monitoring Tool: Comprehensive CNA Shower Review revealed Resident #2 received a shower on 3/3/26 and 3/11/26. The Resident Grievance/Complaint Investigation Report Form dated 3/11/26 documented Resident #2 did not receive a shower for one week due to the facility being short staffed. The form revealed Resident #2's shower sheets were audited and the last shower documented was on 3/3/26. The investigation form documented staff was encouraged to attempt showers regardless of staffing and Resident #2 was offered a shower on 3/11/26. The form documented the grievance/complaint was confirmed. On 3/17/26 at 9:36 AM, Resident #2 reported last Wednesday, 3/11/26 she had a shower and it was her first shower in 13 days. She said the Assistant Director of Nursing (ADON) made sure she got her shower. She reported she missed a shower the day she was at the hospital and the other days the facility was short staffed. Resident #2 reported she did not refuse any showers. She said the staff wrote down that she refused her shower but the shower was not offered.On 3/17/26 at 3:30 PM, the ADON reported when she received the grievance form she had looked into the concern and identified Resident #2 had a bath on 3/3, did not get a bath on 3/6 when she was at the hospital and did not get one on 3/8. She said she apologized to Resident #2 and made sure she got a bath on 3/11. On 3/23/26 at 2:57 PM, the ADON reported she expected showers/bathing to be offered per the shower schedule. She said if the shower/bath was not completed then the expectation was for the resident to have at least one bath/shower per week. She stated if the resident refused the bath/shower a bed bath was to be offered. She said if a bath/shower was refused, the nurse was to make one attempt and document the response.The facility policy titled Bath, Shower/Tub revised February 2018 documented the purpose of the procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The policy directed staff to document date and time the shower/tub bath was performed and if the resident refused the shower/tub bath the reason why, intervention that was taken and to notify the supervisor.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review the facility failed to implement smoking safety interventions for 1 of 3 residents (Resident #3) reviewed for smoking/vaping. The facility reported a census of 34 residents.Findings include: Resident #3's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMs) score of 14, indicating intact cognition. The MDS identified Resident #3 was dependent on staff for bed mobility and transfers. The MDS included diagnoses of diabetes mellitus, arthritis, cerebrovascular accident (CVA/stroke) with hemiparesis (weakness or reduced motor control on one side of the body), and adjustment disorder with mixed anxiety and depressed mood.The Care Plan with a target date of 4/22/26 documented a focus problem related to tobacco usage. The care plan documented Resident #3 was to utilize a smoking apron. The Smoking and Safety assessment dated [DATE] documented Resident #3 displayed balance problems while sitting or standing, limited or no range of motion in arms or hands, insufficient fine motor skills needed to securely hold tobacco or other smoking items and drops ashes on self.The Smoking Assessment documented Resident #3 preferred to wear a smoking apron and was deemed independent with smoking with a safety device required. On 3/17/26 at 11:50 PM, observed Resident #3 outside in the courtyard smoking independently with no smoking apron on. On 3/18/26 at 1:45 PM, observed Resident #3 outside in the courtyard smoking independently with no smoking apron on. On 3/18/26 at 1:53 PM, Staff K, certified nursing assistant (CNA) reported she had assisted Resident #3 outside to smoke. When asked if she had offered a smoking apron, she said no, she was not aware Resident #3 was supposed to use one. On 3/23/26 at 9:41 AM, observed Resident #3 outside smoking with no smoking apron on. The Assistant Director of Nursing (ADON) reported she offered the apron when she went out to smoke and Resident #3 refused it. She reported Resident #3 said the apron complicated her ability to smoke.The undated facility policy titled Smoking/E-Smoking Policy documented it was a policy of the facility to extend the privilege of smoking, vaping, and chewing tobacco in the designated areas to the residents who have signed a smoking agreement. The policy documented residents would be assessed using the Smoking Assessment Form. The form would identify any smoking provision necessary for the safety of the resident. Smoking Assessment may also indicate need for additional interventions such as smoking apron, cigarette extenders, etc. In addition, the policy documented IDCP team would review all residents who participate in the smoking program on a one to one basis and failure to comply with smoking policy would result in counseling and may result in suspension of smoking privileges.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility records, resident interviews, staff interviews, and the facility assessment, the facility failed to provide enough staff to care for residents in a timely manner for 4 of 4 residents reviewed (Resident #1, #2, #7 and #3). The facility reported a census of 34 residents. Findings include 1. The Minimum Data Set (MDS) for Resident #1 dated 2/11/26 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.On 3/16/26 at 2:49 PM, Resident #1 reported on 3/16 she had put her call light on to use the commode, she waited about 20 minutes and had to go up front to find staff to bring her commode in. She said there were a couple other days she waited 30 minutes for staff to come and help her with post toileting hygiene. Resident #1 reported she had the dates written down in her book when she had to wait for help which were on 2/9 and 3/7. In addition, Resident #1 reported on 2/18, 2/20 and 3/2 there were only two certified nursing assistants (CNA) on the floor. She said on 2/18 it took longer to get assistance and on 3/2 there were no baths given due to staffing. 2. The MDS for Resident #2 dated 2/12/26 identified a BIMS score of 15, indicating intact cognition.On 3/17/26 at 9:36 AM, Resident #2 reported she had missed her showers because the facility was short staffed. She said the facility wrote down that she refused her showers but the showers were not offered. The Resident Grievance/Complaint Investigation Report Form dated 3/11/26 documented Resident #2 did not receive a shower for one week due to the facility being short staffed. The form revealed Resident #2's shower sheets were audited and the last shower documented was on 3/3/26. The investigation form documented staff was encouraged to attempt showers regardless of staffing and Resident #2 was offered a shower on 3/11/26. The form documented the grievance/complaint was confirmed. 3. The MDS for Resident #7 dated 12/17/25 identified a BIMS score of 15, indicating intact cognition.On 3/17/26 at 10:28 AM, Resident #7 reported when the staff are busy putting people to bed and she needs something they will tell her she has to wait which will tick her off. She said the facility was always short staffed, usually just two CNAs, one CMA (certified medication aide) and a nurse. She said there are not enough staff. Resident #7 reported long call lights over 15 minutes happen daily. She said she uses a clock on the wall to time the call lights. She said her roommate has waited an hour to get care completed. She said there are 5 CNAs on the floor today because the state was present, she said that was not a coincidence.4. Resident #3's MDS dated [DATE] identified a BIMs score of 14, indicating intact cognition. On 3/23/26 at 9:44 AM, Resident #3 reported she was not offered a bath on Friday, 3/20. She said an agency aide stayed over her shift to do her shower on Sunday, 3/22 or she would not have gotten a second shower during the week. Resident #3 said she was feeling nasty, her hair was stringy and her body was starting to itch. Resident #3 reported staffing had been shitty. She said the gal in Human Resources (HR) has had to work the floor because the facility was short staffed. On 3/23/26 at 2:17 PM, the Assistant Director of Nursing (ADON) reported Resident #3's bath was not offered on Friday evening, 3/20 due to staffing issues related to two call in's. A Resident Grievance/Complaint Investigation Report Form dated 2/11/26 document resident council complained showers were not getting done on scheduled days, due to the facility being short staffed. The corrective action documented two CNA contracts starting at the end of the month. A Resident Grievance/Complaint Investigation Report Form dated 2/11/26 documented Resident #1 was in the bathroom with her light on for 30 minutes waiting for help. Resident #1 reported she needed help wiping and was waiting a really long time. The corrective action was documented to assign more staff and new behavior interventions. A Resident Grievance/Complaint Investigation Report Form dated 3/11/26 documented resident council complained the facility was short CNA's. The corrective action documented was an agency CNA to start on Monday. The form documented the grievance/complaint was confirmed.Review of the Daily Nursing Assignment Sheets from February 9th, 2026 to March (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2026 revealed the following staffing on the day shift 6 AM To 2 PM:2/9- 1 Nurse, 1 CMA, 3 CNA 2/10- 1 Nurse, 1 CMA, 1 CNA 6AM to 2 PM and 1 CNA 10:30 AM to 2 PM2/12- 1 Nurse, 1 CMA, 2 CNA2/13- 1 Nurse, 1 CMA, 2 CNA2/17- 1 Nurse, 1 CMA, 2 CNA and a 3rd CNA at 12 PM2/18- 2 Nurses, 2 CNA2/20- 1 Nurse, 2 CNA2/23- 2 Nurses, 2 CNA2/25- 2 Nurses, 2 CNA2/27- 1 Nurse, 2 CNA2/28- 1 Nurse, 1 CMA, 2 CNA and a 3rd CNA at 10 AM3/1- 1 Nurse, 2 CNAs and a 3rd CNA at 10 AM3/2- 1 Nurse, 2 CNA and a 3rd CNA at 10 AM3/5- 1 Nurse, 1 CMA, 1 CNA and a 2nd CNA at 10 AM3/6- 2 Nurses, 2 CNA, and a 3rd CNA at 10 AM3/7- 1 Nurse, 1 CMA, 2 CNAs3/9- 2 Nurses, 2 aides, and a 3rd CNA at 10 AM3/12- 1 Nurse, 1 CMA, 2 CNAs and a 3rd CNA at 10 AM3/13- 2 Nurses, 2 CNAs and a 3rd CNA at 10 AM3/14- 1 Nurse, 1 CMA, 2 CNAs and a 3rd CNA at 10 AMThe Facility assessment dated [DATE] completed by the Administrator documented the nurse staffing plan for 32 residents included the following:Dayshift:RN (Registered Nurse) or LPN (Licensed Practical Nurse)- 1CNA- 4CMA-1Evenings:RN or LPN- 1CNA-3CMA-1Nights:RN or LPN-1CNA- 2CMA-0On 3/18/26 at 8:42 AM, the Social Services Director reported staffing has been very rough and the facility had been short staffed. She said on the 6 AM- 2 PM (dayshift), there were times there were two CNAs and sometimes only one CNA on the floor. She said herself and the HR director would have to jump in and help as they are both CNAs. She reported this has happened around once a week over the past month. She said resident needs are being met but there are times when the call lights are longer due to less workers. She said they do stop in the resident room to let them know they will be back as soon as possible. She said the longer call lights are 15-20 minutes in length.On 3/18/26 at 10:26 AM, the Executive [NAME] President for Clinical Services reported the facility did not have the capability of running a call light report and she could not locate any call light audits for the building. On 3/19/26 at 10:00 AM, the Administrator said the dayshift staffing has been sketchy and rough. She said they would pull the CMA off the medication cart to help on the floor if needed. She said the HR Director and Social Services Director would help on the floor if needed as they are both CNAs. She said she would come in and help answer call lights or do baths. She said from 6 AM to 10 AM was the time of the struggle. She said they could usually get another person in around 10 AM. The Administrator said she can go to bed at night with a full staff schedule and then in the morning there would be call ins. She said the 2nd shift staff will try to make up what they can. She said she has had to come in to be the nurse. When asked about call light response time, she said there are some residents that take an extensive period of time. She said you can't spend 8 hours straight with one person.On 3/23/26 at 2:17 PM, the ADON reported the expectation was for the call lights to be answered as soon as possible within 15 minutes. She said any staff member can answer the call light and try to meet immediate needs. She reported there have been complaints from residents regarding long call lights on days when the facility was short staffed (less than 3 CNAs). She said Monday through Friday when the management team members are present, call light times are better. She said on weekends she was always chasing the call lights. The facility policy titled Answering the Call light dated 2001 documented the purpose of the procedure was to ensure timely responses to the resident's requests and needs. The policy directed staff to answer the resident call system immediately and complete the following items:a. If the resident needs assistance, indicate the approximate time it would take to respond. b. If the resident's request requires another staff member, notify the individual.c. If the resident's request was something the staff member could fulfill, complete the task within 5 minutes if possible. d. If uncertain whether or not the request can be fulfilled, ask the nurse supervisor for assistance.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigative file review, observation, staff interviews, and facility policy review the facility staff failed to document on the Controlled Substance Record and the electronic Medication Administration Record (MAR) when morphine and lorazepam medications were administered for 2 of 3 residents reviewed for controlled substance use (Resident #6, and #12). The facility also failed to destroy controlled substance medication after 90 days. The facility staff also failed to ensure medication was properly dispensed from the medication bubble pack, and failed to dispose of medication when a pill was inadvertently dropped on the medication cart for 1 of 4 residents observed for medication administration (Resident #13). The facility also failed to complete medication reconciliation for a controlled substance for 1 out of 4 residents reviewed (Resident #3). The facility reported a census of 34 residents. Findings include: 1.A Facility Self Report to the Department of Inspections, Appeals and Licensing (DIAL) by the Administrator on [DATE] at 10:44 PM revealed the liquid morphine (an opioid narcotic used for pain) count was short 1.5 milliliters (ml) at shift change. Resident #6 had an order for 0.25 ml sublingually (SL) every (q)2 hours as needed (PRN). An audit of the administration log did not immediately reveal a discrepancy so drug diversion could not be ruled out. The police was notified of the missing narcotic. A QA (Quality Assurance) audit of all narcotics was completed by the nurse and Director of Nursing (DON) on this date with no additional discrepancies found. Resident #6 was the only resident that had a liquid narcotic medication. A random narcotic count audit was conducted by the Administrator (also a Licensed Practical Nurse (LPN)), the DON, and the Assistant DON (ADON) daily for 7 days pending the investigation results. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had diagnoses of cerebrovascular accident (CVA) (stroke), hemiplegia (paralysis on one side of the body), and chronic pain. The MDS recorded the resident was on hospice and took antianxiety and opioid medications during the 7-day look-back period. The Care Plan revealed Resident #6 had chronic pain. The Care Plan directed staff to monitor the resident for pain and anxiety, and administer morphine and/or lorazepam (an antianxiety) medications per the physician's order. The Medication Administration Record (MAR) revealed the following orders: a. Give morphine solution 0.25 ml SL q2hours PRN for pain or shortness of breath (SOB) had a start date of [DATE]. b. Give lorazepam concentrate 0.5 ml PO q2 hours PRN for restlessness and/ or anxiety had a start date [DATE]. The Controlled Medication Utilization Record 11/1 to [DATE] revealed: a. One- 30 ml bottle of lorazepam was received on [DATE]. Staff continued to document the medication dose administered until the date of [DATE] when it was noted the medication was past the 90 days and had expired. The remaining amount of 13 ml was destroyed by two staff on [DATE]. b. Lorazepam was signed out on the Controlled Medication Record but not recorded on the MAR: 11/1 – [DATE] – 6 of 11 x's. The count was corrected on [DATE] at 6:56 AM due to 0.5 ml not recorded for 2 dates. 12/1 – [DATE] – 1 of 4 x's 1/1 – [DATE] – 1 of 4 x's c. Lorazepam was documented on the MAR as given but not signed out on the controlled substance record on 11/3 at 8:28 PM, 11/9 at 10:45 AM and [DATE] at 4:00 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Controlled Medication Utilization Record revealed morphine 0.25 ml (5 mg) PRN signed out on the utilization record but not documented on the MAR on the following: 11/1 to [DATE] – 33 of 83x's 12/1 to [DATE] – 40 of 77x's 1/1 to [DATE] -18 of 64x's In addition, the following discrepancies were found on the Controlled Medication Utilization Record for liquid morphine (received [DATE]):a. Line 7 and Line 8 documented the same remaining amount as 28.25 even though 0.25 ml was given on [DATE] at 1:35 AM and 9:25 AM. (0.25 ml was not subtracted correctly)b. Line 23 recorded 24.5 ml remaining, but Line 24 recorded 23.75 after 0.25 ml was given on [DATE] at 10 PM. (0.75 not accounted for).c. Line 43 recorded 19.0 remaining, but Line 44 recorded 17.75 after 0.25 ml was given on 12/19 at 8 AM. (1.25 ml not accounted for)d. Line 75 recorded 10.0 ml remaining but Line 77 documented a count of 9.75 but then a 2 written over the 7in blue ink (creating a 0.75 ml discrepancy in the count). e. An add-on page to the Controlled Medication Utilization Record carried over [DATE] revealed that on [DATE] 1.5 ml amount remaining and a new 30 ml bottle of liquid morphine received on [DATE]. 1.5 ml from the previous bottle was unaccounted. An Incident Report filled out by Staff D, Registered Nurse (RN), dated [DATE] at 7:45 PM revealed Staff D was notified at home that there was a discrepancy in the count of Resident #6's PRN liquid morphine. Staff D discussed the protocol with the Administrator and attempted to identify the discrepancy. After identification, the Police Department was notified at 10:20 PM and came to the facility to do a theft investigation. Copies of narcotic sheets were given to the police officer. Facility Investigation File revealed: On [DATE], Resident #6's morphine bottle was empty however the count showed the bottle should still contain 1.5 ml of liquid morphine. The nurses on duty reviewed the count reviewed and were unable to determine a reason for why the narcotic count was short. An immediate self-report and investigation for possible diversion was initiated. An extensive review of documentation showed multiple transcription errors on the paper narcotic log including: On [DATE], Line 7, the end count was transcribed as 28.25 ml for a second time (-0.25 ml). Staff G, certified medication aide (CMA), did not subtract the amount. On [DATE], Line 22, documented the count as 24.75. On line 23, a dose of 0.25 ml was given and the end count was transcribed to 24.0 ml (+0.5 ml). Staff A, CMA, over subtracted the dosage leading to an additional shortage. Upon inspection, the error appeared to be related to handwriting. On [DATE], Line 43, documented the count was 19.0. On Line 44, a dose of 0.25 ml was given and the end count was transcribed as 17.75 ml (+1.0). Staff A over subtracted the dosage leading to an additional shortage. On [DATE], Line 77, documented a count of 9.75. Staff H, agency RN, used a blue pen to correct her error to this number. On Line 78, a dose of 0.25 ml was given and the end count was transcribed at 9.0 ml (+0.5 ml). Staff I, CMA, over subtracted which led to an additional shortage. Additional transcription errors brought the liquid morphine count shortage to a total 3.5 ml. The paper administration record dated [DATE] - [DATE] revealed 107 doses of liquid morphine was recorded. On the electronic MAR (EMAR), 41 doses of liquid morphine were recorded for the same period. The investigation supported multiple documentation errors related to liquid morphine administration. Resident #6 was noted to have severe anxiety with incidents of SOB and treated with liquid morphine. The resident's q2hours dosage was frequently utilized in moments when the resident had extreme anxiety due to SOB. A Root Cause Analysis reflected: new CMA's, staff distraction during the documentation phase, and urgency of resident's needs for relief were factors that led to charting errors and caused the inaccurate counts. The facility's investigation file revealed the facility provided education to the nurses and CMA's about narcotic medication administration and documentation, completed random QA audits of narcotic counts, and audits comparing narcotic medications administered to the written narcotic record against the EMAR documentation (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 2:00 PM, Staff A, CMA, reported whenever she was going to give a controlled substance, she first checked the MAR and the controlled substance record to ensure the count was correct before she pulled the medication out of the medication cart. She then popped the medication from the card and signed out the medication on the controlled substance form right away. Then she clicked the medication on the EMAR, gave the medication to the resident, and then came back and signed the medication off on the MAR. Staff A reported narcotic counts are done every shift and whenever there was a change over with staff such as at shift change or when staff went on break. Two staff signed on the controlled substance inventory count sheet whenever a narcotic count was completed. Whenever a medication card was added or removed from the medication cart, they recorded the information (resident name, medication and dose) on the inventory sheet. Staff A reported the nurse had to do an assessment including the pain level before the CMA could give any PRN narcotic /controlled substance medications. The nurse also had to follow up after the medication was administered to see if the medication helped. Staff A confirmed she was working during the time when there was a discrepancy with Resident #6's bottle of liquid morphine. Staff A stated she asked the nurse to do a follow up because Resident #6 was in a lot of pain and on hospice so that she could give the resident something for pain. She let the nurses know for 2 weeks that the count was going to be off. Staff A stated since she is a CMA, she is not able to correct the count. The nurses she told were Staff B and Staff E. Staff A stated she did not fill out an incident report. She got written up for not documenting the medication on the MAR. In an interview on [DATE] at 2:25 PM, Staff B, RN, reported the process for administering a controlled substance: Sign out the narcotic / controlled substance in the book (controlled substance record) for the resident and on the MAR. Staff B reported narcotic counts are done at shift change and whenever he went on break. Two staff had to sign whenever a narcotic count was completed. Staff B reported he would let the DON know and fill out an incident report if there was a discrepancy in the count. In an interview on [DATE] at 9:55 AM, the Administrator reported she got a call from the night shift nurse that there was a discrepancy in the liquid morphine count. Staff C, LPN, was the night nurse. Staff C said she was not taking the (medication) cart until someone addressed the shortage of the liquid morphine. The Administrator stated she called Staff D, the DON at the time. The DON reviewed everything. The Administrator reported they mostly found that the medication was documented on the paper log but not on the MAR. After they did more research and worked with pharmacy, they found that staff were not documenting the medication in both places. The Administrator explained that one month before this, Resident #6 had SOB and anxiety to the point the resident thought staff were leaving her. The Administrator had a conversation with the team and told the staff they needed to get the resident's medications to her quick but not so quick that they don't write it down. The main thing was to get staff to write the medication on the paper log and on the EMAR. The Administrator stated as she and the DON did audits, they found more concerns with staff not getting the medication written done. She felt it was sloppy on the part of staff documenting the medication. She had to demote a CMA because the CMA did not document the medication and there were problems with a bunch of staff making mistakes. The Administrator confirmed they did a look back to 12/2025 which was about two months of the bottle that was in use at that time. The Administrator reported she expected staff to get another sheet when they ran out of lines on the controlled substance record rather than continue to write past the lines on the blank portion of the page. She thought it depended on who it was and if additional copies of the narcotic form was made. The Administrator decided they did not find a discrepancy in the count or that the liquid morphine was missing but rather the staff had not subtracted correctly or did not sign the medication out. The Administrator stated training provided to staff and audits were conducted. They also found issues with charting by certain staff and staff had to be terminated or demoted. The Administrator reported she expected staff to do an evaluation on a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checked the controlled substance log for each resident in the controlled substance book. During the count, Resident #12's Tramadol 50 mg bubble pack card revealed 6 tablets left but the Controlled Medication Utilization Record form for Resident #12 revealed 8 tablets remaining. Staff A reported she just gave the resident the medication and she had not had a chance to sign the medication out on the controlled medication form. Staff A then wrote [DATE] and 1 on the controlled medication form on line 86 and line 87. Staff A then checked the EMAR. The times on the computer screen revealed both tabs were documented as given at 1155 and 1156. Staff A reported she did not know why the time showed up like that, but she had to go back into the EMAR to check the time she gave the medication. As the surveyor and Staff A continued the count, another discrepancy was noted on Resident #6's liquid morphine. The morphine bottle had the seal intact and bottle in the box dispensed from the pharmacy. The controlled drug utilization record revealed a morphine dose given and signed out on [DATE] at 10:30 PM by MW LPN. The amount remaining 29.75 was crossed off and 30 was written in under the column wasted. Staff A reported she thought the nurse wrote on the wrong form, but she was not sure why. There were no documentation or staff initials by the item that had been crossed off. Review of the Medication Admin Audit Report dated [DATE] revealed Tramadol 50 mg scheduled times at 8:00 AM and 11:00 AM. The report revealed the tramadol administration time was at 7:45 AM but documented at 2:41 PM by Staff A (after the narcotic count was completed with the surveyor and Staff A). Review of the Progress Note revealed Tramadol 50 mg PO for pain recorded an effective date of [DATE] at 7:45 AM and a created date of [DATE] at 2:41 PM by Staff A. In an interview on [DATE] at 11:45 AM, Staff E, RN, reported she assumed the interim DON role in the past week. Staff E reported scheduled and PRN narcotic medications were signed out right away when the medication was removed from the medication cart and then charted the medication on the EMAR. In an interview on [DATE] at 11:00 AM Staff D, RN, explained the process for administering controlled substances such as liquid morphine: The CMA or nurse should check the amount on the medication card/bottle, remove the medication, sign out the medication on the paper form (controlled substance record), give medication to the resident, and mark the medication off on the EMAR. The nurse or CMA needed to enter the date, time and dose on the controlled substance record and subtract from the total amount that was listed from the remaining amount before. 3. The MDS assessment dated [DATE] revealed Resident #13 had diagnosis of hypertension (high blood pressure), pain and depression. On [DATE] at 8:00 AM, Staff F, CMA, checked the computer, then removed medication bubble cards from the medication cart for Resident #13. Staff F prepared medications and placed the medications into a medication cup: a. ropinirole (medication to treat Parkinson's and restless leg syndrome) 0.5 mg b. amlodipine (used to treat high blood pressure) 10 mg c. lisinopril (used to treat high blood pressure) 40 mg d. sertraline (an antidepressant) 50 mg At 8:01 AM, Staff F took the medication cup with pills into Resident #13's room. Staff F handed the resident the medication cup with pills. Resident #13 stated there were only 3 pills and he thought there should be 4. Resident #13 stated the yellow pill was missing. Staff F stated maybe the pill did not pop completely out of the medication card and reported she would go check. Staff F took the medication cup from the resident and went to the medication cart, pulled out the medication cards and found the card with the yellow pill. The bubble (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The February 2026 Medication Administration Records (MAR) directed staff to administer the following medications: 1. Morphine Sulfate ER (extended release) 15 mg (milligrams) three times a day related to chronic pain. 2. Morphine Sulfate 15 mg every 12 hours as needed for chronic pain. The Shipment Summary for Resident #3's Morphine Sulfate ER 15 mg revealed on [DATE] at 8:50 PM the facility received 30 tablets. Review of the Clinical Record lacked a Narcotic Administration Record and Reconciliation for the Morphine Sulfate ER 30 tablets received on [DATE]. On [DATE] at 12:50 PM, the Assistant Director of Nursing (ADON) reported she had confirmed from the Pharmacy, Resident #3's Morphine ER was delivered on [DATE]. She said she could not locate a narcotic administration record for the Morphine ER that was delivered on [DATE]. On [DATE] at 7:19 PM, the ADON reported the missing narcotic administration record had not been located. On [DATE] at 8:50 AM, the Executive [NAME] President of Clinical Services reported the Morphine ER narcotic administration record was not located. She said the delivery sheet was located and the number of pills delivered matched up to the MAR. She said the process was to scan the completed narcotic administration record in the electronic medical record and then shred the form. She said the facility did not have a validation process with scanning and that the process would have to be adjusted. She reported she expected a narcotic administration record and reconciliation to be completed with controlled substances. The facility policy titled Controlled Substances revised 11/2022 documented controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record. If the count is correct, an individual resident controlled substance record was to be made for each resident who will be receiving a controlled substance.

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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** Based on clinic record review, resident interview, staff interviews, and policy review, the facility failed to administer medications per physician orders for 2 out of 6 residents reviewed (Resident #3 and #2) for significant medication errors. The facility reported a census of 34 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMs) score of 14, indicating intact cognition. The MDS identified Resident #3 was dependent on staff for bed mobility and transfers. The MDS included diagnoses of diabetes mellitus, arthritis, cerebrovascular accident (CVA/stroke) with hemiparesis (weakness or reduced motor control on one side of the body), and adjustment disorder with mixed anxiety and depressed mood. The MDS documented Resident #3 had received opioid pain medications during the last 7 days.The Care Plan with a target date of 4/22/26 documented Resident #3 was at risk for adverse reactions related to polypharmacy. The care plan documented a medication error on 2/22/26 with a mix up between Morphine ER (extended release opioid pain medication) and Morphine IR (immediate release). In addition the care plan documented Resident #3 had chronic pain related to chronic physical disability hemiparesis and contracture. The care plan revealed Resident #3 preferred to have pain controlled by schedule and as needed (PRN) Morphine and PRN muscle relaxant. The February 2026 Medication Administration Records (MAR) directed staff to administer the following medications:1. Morphine Sulfate ER 15 mg (milligrams) three times a day related to chronic pain2. Morphine Sulfate 15 mg every 12 hours as needed for chronic painThe Progress Note on 2/21/26 documented the facility received a phone call from the pharmacy reporting Resident #3's Morphine ER 15 mg was not on hand and the pharmacy was waiting for the manufacturer to deliver the medication. The note documented the on-call provider was notified and gave directions to continue giving the PRN Morphine until the extended release Morphine was available. The Incident Report (IR) titled Medication Error dated 2/22/26 documented a medication error had occurred with Resident #3's Morphine. Resident #3 was scheduled to receive Morphine ER (extended release) 15 mg three times daily and she received Morphine IR (immediate release) at 7 AM, 10 AM and 1 PM. The IR documented Resident #3 stated she was under the understanding that she was able to take the medication every 8 hours like would have the Morphine ER so that is what she told the certified medication aide (CMA) and the CMA gave it to her. A Resident Grievance/Complaint Investigation Report Form dated 2/23/26 documented a complaint that Resident #3 was overdosed by the CMA. The form documented the Morphine ER medication was out of stock and the CMA gave the Morphine IR in its place. The form documented the grievance/complaint was confirmed.The Narcotic Controlled Medication Utilization Record directed staff to administer Morphine IR 15 mg twice daily as needed for pain. Review of the narcotic record revealed Morphine IR was given on 2/22/26 at 7:50 AM, 10:22 AM and 1:00 PM. The Clinical Record lacked a Narcotic Controlled Medication Utilization Record for the Morphine ER on [DATE]. Review of the February MAR revealed the Morphine Sulfate ER was documented as given on 2/22/26 at AM and Noon. The Morphine Sulfate IR was documented as being given on 2/22/26 at 7:49 AM. On 3/23/26 at 9:44 AM, Resident #3 reported a medication aide gave her too many doses of Morphine IR in a short amount of time. She said on Sunday, the 22nd, she woke up and did not know what day it was and thought Saturday was a hallucination. She said she was so messed up and the error was traumatic for her. She said there was a nationwide shortage with the Morphine ER. She said the medication aide gave her immediate release Morphine in place of the extended release Morphine. On 3/23/26 at 12:10 PM, the Pharmacist stated she was not aware of the morphine medication error with the resident. She stated with her previous history and taking morphine 15mg ER three times a day, which is already more than necessary and also on morphine PRN, she can't say if there would be a potential negative reaction. She said she may have been a little bit more tired. On 3/23/26 at 12:15 PM, the Assistant Director Nursing (ADON) reported the Morphine error occurred on 2/22/26. She said she called the (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	03/24/2026

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician herself to report the error. She said the Nurse on the 2/21/26 did not put the Morphine ER order on hold so the order was still showing up on the MAR to be given. She said Staff J, CMA thought the immediate release Morphine was being given in place of the extended release Morphine. She said Staff J, CMA signed off the Morphine ER on the MAR but gave the immediate release. On 3/23/16 at 1:00 PM, Staff J, CMA reported Resident #3's Morphine ER medication had run out and the nurse had instructed her to give the Morphine IR medication in its place. She said the nurse was not helpful and was on his phone a lot. She said Resident #3 liked to take her pain medications in bed before getting up. She said she gave her the PRN Morphine IR in bed at 7:50 AM and then when she got up gave her the scheduled Morphine at 10:22 AM and then again at 1:00 PM. She said she signed off that she gave the Morphine ER on the MAR but gave the Morphine IR. Staff J acknowledged she had given the Morphine IR to close together and did not follow the physician order.On 3/23/26 at 3:23 PM, Staff C, Licensed Practical Nurse (LPN) reported the facility did not have the scheduled Morphine available for Resident #3. She said they only had the PRN Morphine available. She said Resident #3 had called and asked about her Morphine. She said she looked at the narcotic record and saw there had been 3 doses of the Morphine IR given in a short period of time. She said she alerted Staff D, former Director of Nursing (DON) and the ADON of the medication error. 2. The MDS for Resident #2 dated 2/12/26 identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), kidney disease, hyponatremia (low sodium levels), and edema. The March 2026 MAR directed staff to administer the following medication orders:1. Potassium Chloride ER 20 mEq (milliequivalents) one time a day every other day for hypokalemia (low potassium). 2. Potassium Chloride ER 40 mEq one time a day every other day for diuretic use. Resident Grievance/Complaint Investigation Report Form dated 3/11/26 for documented a medication dose was incorrect as Resident #2 was supposed to receive 40 mEq of Potassium and received 20 mEq. The form documented the grievance/complaint was confirmed. The IR titled Medication Error dated 3/11/26 documented Resident #2 reported she received 20 mEq of Potassium instead of 40 mEq as ordered. The IR documented the medication card was checked with the nurse and visualized the medication for this day was still in the card. The nurse had only given 20 mEq of Potassium and not 40 mEq. The nurse reported she was confused as there were separate medication cards for separate days as she got 20 mEq one day and 40 mEq on the opposite day. Review of the March MAR revealed Potassium 40 mEq was signed off as administered on 3/11/26. On 3/17/26 at 9:36 AM, Resident #2 reported she was supposed to get four Potassium pills and she only got two pills. She said she thought the medication error occurred about 3 weeks ago. She reported a grievance form was completed regarding the medication error. On 3/23/26 at 2:57 PM, the ADON reported her expectation was for the staff to follow 5 rights of medication administration, compare the medication card to the medication administration record and if is the staff member has not worked at the facility before to use the two identifier method to ensure the right patient. She said if a medication error occurs, she would expect the staff to check on the resident, notify the Physician, complete risk management documentation and notify the family or responsible person. The facility policy titled Administering Medications revised April 2019 documented medications are administered in a safe and timely manner, and as prescribed. The individual administering the medication is to check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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	165426	A. Building B. Wing	03/24/2026

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Aspire of Perry	2625 Iowa Street Perry, IA 50220

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility records, staff interviews and policy review the facility failed to ensure menus/recipes were followed and meal substitutions approved by a Registered Dietician to ensure the nutritional needs of the residents were being met. The facility reported a census of 34 residents.Findings include: The Employee Counseling Form (written warning) dated 2/9/26 documented Staff L, [NAME] changed the menu on 2/7/26 when he was told not to. The form documented going forward Staff L was to make what was on the menu and/or follow the recipes that were given. The Resident Grievance/Complaint Investigation Report Form dated 2/11/26 documented resident council complained hamburger patties were used to make [NAME] sandwiches instead of corned beef. The corrective action was to look at the recipe more carefully and follow the recipe exactly. The form documented the grievance/complaint was confirmed.The Employee Counseling Form (final written warning) dated 2/16/26 documented the Dietary Manager on 2/14/26 made substitutions to the menu without consulting the dietician first and made unauthorized purchases on behalf of the company. The form documented regulations require the staff to call dietician for approved substitutions and to call the Administrator for card to purchase. On 3/18/26 at 8:42 AM, the Social Services Director reported there had been some issues with the dietary menus not being followed due to last minute changes or items not showing up on the delivery truck. She said she does not believe the Dietician was always notified of the changes with the menus. She said she thinks substitutions happen about every other week. On 3/18/26 at 3:35 PM, the Dietary Manager reported that sometimes the kitchen would have to substitute or switch it up if she forgot to order something or the item did not come on the food truck. She said she would let the Dietician know if she had to substitute an item. When asked about the grievance with corned beef, she said the cook got confused and was having a brain moment and used ground beef instead of corned beef. She said the cook corrected it the next time and followed the recipe. The Dietary Manager reported there was a time when she forgot to order the pizza crust and the menu called for pepperoni pizza. She said they had the rest of the ingredients except for the crust. She said she went out and bought frozen pepperoni pizza for the residents. She said she told the Dietician and she said it was a problem because one resident was on a no added salt diet (NAS). She said she removed the pepperoni from the pizza. She said the Administrator yelled at her for getting the frozen pizzas and told her not to go behind her back again or she would be fired. She said she received a final warning for getting the frozen pizza. On 3/19/26 at 8:51 AM, the Registered Dietitian reported there had been concerns with the Dietary Manager not ordering the correct amount of food and purchasing other products. She said one example was the Dietary Manager did not have the ingredients to make the pizza dough so she went out and bought frozen pizza. The Dietician reported she was not being informed on a regular basis when substitutions were happening. She said the expectation was to call regarding menu changes. She said on 1/31/26 there was a dietary meeting with all cooks and dietary aides to go over expectations to call or email when substitutions are made. She said she thought the Dietary Manager panics, goes to the store and gets the easiest thing. She said her concern with the frozen pizza was there were several residents with weight loss goals and with fluid retention. The Dietician said she was concerned with the amount of sodium in the pizza. She said taking the pepperoni off the pizza was not ideal. She said with frozen pizza the serving sizes would have also been different than using the frozen dough. She said there was another time instead of following the recipe for a soup, the dietary staff served beef ravioli out of a can.On 3/19/26 at 10:00 AM, the Administrator said she had caught the kitchen staff making substitutions on the menu. She said she had the Dietary Manager write up a cook for making a substitution and not notifying the Dietician. She said the next week the Dietary Manager bought frozen pizza and did not tell her or the Dietician about the substitution. She said the Dietary Manager was the boss and knew (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this was not acceptable. She said the pepperonis were taken off the pizza for the NAS diets. She said the dietary manager went behind her back and bought the frozen pizza. The Administrator reported she expected the dietary staff to talk to the Dietician before substitutions were made and come to the Administrator before buying it. She said she needed to be serious with the Dietary Manager as she expected better and wanted to get the problem addressed. On 3/19/26 at 11:30 AM, the Dietary Manager acknowledged giving a written warning to Staff L, [NAME] for not following the menu on 2/7/26. She said Staff L did not make the ground beef stew per the recipe. She said the beef stew was served out of a can. The Dietary Manager provided menus for the ground beef stew on 2/7/26 and the pepperoni pizza on 2/14/26. She said the dates documented on the menus are not correct and do not line up with the calendar dates. She said the dates are confusing. Review of the Fall/Winter 2025 week 3 menu documented pepperoni pizza was on the menu for Saturday at dinner and the week 4 menu documented ground beef stew was on the menu for Saturday at lunch. Review of the Diet Type Report dated 2/14/26 documented one resident on a NAS diet, one resident on a consistent carbohydrate diet and one resident on small portions.On 3/23/26 at 2:17 PM, the Assistant Director of Nursing (ADON) reported it had been identified a long time ago that the menus were not being followed. She said it was an expectation that if the menu could not be followed then any substitution needed to be approved by the Dietician. She said she was working one weekend, and she witnessed the Dietary Manager take the credit card to buy frozen pizza. She said she reported it to the Administrator as frozen pizza was not on the menu and the facility was not in compliance. She said the Dietary Manager got a final write up related to using substitutions without the Dietician approval. She said the Dietary Manager told the residents about it and the residents got upset with the Administrator. The facility policy titled Menus revised October 2017 documented menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. The policy documented the Dietician to review and approve all menus. Deviations from posted menus are recorded (including the reasons for the substitution and/or deviation) and archived.