Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/05/2026
Form Approved OMB
No. 0938-0391

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	01/14/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy review, the facility failed to correctly use a mechanical lift during a transfer for 1 of 5 residents (#13) by keeping the mechanical lift's legs closed while moving the resident from his bed to a wheelchair. The facility reported a census of 32 residents.Findings include:On 1/11/26 at 4:01 PM, Staff D, Certified Nurse Aide (CNA) and Staff E, CNA entered Resident #13's room to transfer him from his bed to a wheelchair. Staff D positioned the resident's wheelchair at an angle at the foot of the resident's bed. After Staff D and E positioned the mechanical lift sling under the resident, Staff E positioned the mechanical lift over the resident's bed and connected the sling to the mechanical lift. Staff E raised the resident off the bed, backed the mechanical lift and resident away from the resident's bed, turned the mechanical lift toward the wheelchair, and pushed it to the front of the wheelchair. Once the mechanical lift was at the front of the wheelchair, Staff E opened the mechanical lift's leg to fit around the wheelchair, positioned the resident over the wheelchair, and lowered him onto the seat.The Minimum Data Set (MDS) assessment for Resident #13 dated 1/07/26 revealed a Brief Interview for Mental Status (BIMS) score of 05 out of 15 which indicated severely impaired cognition. It included diagnoses of left lower leg bone fracture, a stroke, and constipation. It indicated he required setup assistance with oral hygiene, supervision with eating, maximal assistance with rolling left-to-right, and was dependent with all other Activities of Daily Living (ADLs) and mobility.The Electronic Health Record (EHR) included a physician's order dated 1/02/26 for the resident to not bear weight on his left, lower leg for 8-12 weeks until his follow-up orthopedic appointment.The Progress Notes revealed the facility used a mechanical lift to obtain the resident's weight during his admission on [DATE].The undated Care Plan revealed the resident usually required 2-staff use of a mechanical lift for chair/bed-to-chair transfers.On 1/14/26 at 7:47 AM, Staff C, CNA stated the mechanical lift's legs should be opened to safely distribute the resident's weight when actively transferring a resident. She also stated the mechanical lift's legs should be closed only if it was necessary to accommodate object limitations.At 8:23 AM, Staff G, CNA stated the mechanical lift's legs should be opened when moving a resident and should be closed only if it was necessary to accommodate barriers.On 1/14/26 at 12:28 PM, the Director of Nursing (DON) stated staff should have opened the mechanical lift's legs at the first available moment.On 1/14/26 at 2:25 PM, the facility confirmed there were five (5) residents who were dependent on a mechanical lift for transfers.A policy titled Lifting Machine, Using a Mechanical revised July 2017 indicated The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions.The manufacturer's user manual specified The legs of the patient lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs to maneuver the patient lift under a bed, close the legs only as long as it takes to position the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165426	A. Building B. Wing	01/14/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient lift over the patient and lift the patient off the surface of the bed. When the legs of the patient lift are no longer under the bed, return the legs to the maximum open position.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Aspire of Perry		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, clinical record review, resident and staff interviews, and policy review, the facility failed to provide pain management for 1 of 1 resident (#13). The facility reported a census of 32 residents.Findings include:On 1/11/26 at 2:34 PM, Resident #13 was heard yelling from his room he wanted his pain medication.The Minimum Data Set (MDS) assessment for Resident #13 dated 1/07/26 revealed a Brief Interview for Mental Status (BIMS) score of 05 out of 15 which indicated severely impaired cognition. It included diagnoses of left lower leg bone fracture, a stroke, and constipation. It indicated he required setup assistance with oral hygiene, supervision with eating, maximal assistance with rolling left-to-right, and was dependent with all other Activities of Daily Living (ADLs) and mobility. It also indicated the resident received pain medication as needed for the previous 5 days. It further indicated the resident experience frequent, severe pain that frequently affected sleep and almost constantly affected day-to-day activities.The Electronic Health Record (EHR) included a physician's order dated 1/03/26 for an opioid for pain management every four (4) hours as needed.The Progress Notes dated 1/11/26 revealed the resident's last pain medication administered was on 1/11/26 at 00:27 AM.The undated Care Plan included an acute pain focus and directed staff to administer pain medications per order, if non-medication interventions are ineffective. It also directed staff to evaluate the resident's pain.At 3:12 PM, the resident was observed sitting up from a lying position. Staff D, Certified Nurse Aide (CNA) entered the resident's room and he told her he had to urinate. Staff D got Staff E, CNA to assist her with helping the resident stand to use his urinal. Resident #6 asked both Staff D and Staff E for pain medication.At 3:22 PM, Staff D confirmed Resident #13 requested medication for pain and constipation. She told the resident the nurse was already made aware of both medication requests.At 3:27 PM, Staff F, Certified Medication Aide (CMA) was observed serving popcorn to the residents in the lobby watching a movie.At 3:38 PM, the resident stated his lower back and both upper legs hurt. He said he had not received his pain medication yet and wanted it. He rated his pain at a 9.5 on a 0-10 scale with 10 being the worst pain.At 3:52 PM, Staff F was observed transporting the popcorn machine from the lobby to a storage room. When she returned, she took the med cart and went down a different resident hall.At 3:56 PM, Staff D and Staff E entered Resident #13's room to transfer him to his wheelchair. The resident told Staff D and Staff E that he wished he had a pain pill. Staff E told the resident the nurse was coming around with the medication cart. The resident repeated he wanted something for his pain and a bowel movement. Staff D told the resident they already informed the nurse.At 4:05 PM, the resident repeated his request for a laxative and a pain pill when he got up.At 4:08 PM, the resident stated the two things he needed was a pain pill and a laxative. He said he couldn't poop.At 4:10 PM, Staff D wheeled the resident to a dining room table with his back to the nurses' station and went on her 15-minute break. At 4:13 PM, Staff F, CMA, approached Resident #13 and asked him if he wanted his pain pill. She went to the cart and got his pain pill. A Progress Note in the EHR dated 1/11/26 at 4:14 PM revealed the resident received his pain medication.At 4:20 PM, Staff F stated she informed Staff A, Registered Nurse (RN) to assess Resident #13's pain level. He documented a 7 out of 10.On 1/14/26 at 12:28 PM, the Director of Nursing (DON) stated staff should've consulted the nurse to immediately assess the resident' pain and administer the resident's pain medication.A policy titled Pain Assessment and Management revised April 2025 indicated a comprehensive pain assessments are conducted upon admission, quarterly, whenever there is a significant change in condition, and when there is an onset of new pain or worsening of existing pain. It also indicated the medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.

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	01/14/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, clinical record review, resident and staff interviews, and policy review, the facility failed to correctly administer insulin to a resident (#10). Staff administered insulin with an undated, previously opened multidose insulin pen. Staff also failed to prime a newly attached insulin pen needle before administering it. The facility reported a census of 32 residents.Findings include:On 1/11/26 at 2:34 PM, Resident #10 stated he used insulin and his blood sugars were sometimes elevated after lunch.The Minimum Data Set (MDS) assessment for Resident #10 dated 10/22/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of high blood pressure, kidney failure, diabetes mellitus, and morbid obesity. It indicated he required setup assistance with eating, supervision for bathing, and was independent for all other Activities of Daily Living (ADLs) and all mobility. It also indicated he received insulin injections 7 days within the 7-day look-back period.The Electronic Health Record (EHR) included a physician's order dated 1/02/26 directed staff to administer 10 units (u) of short-acting (30-minute onset) insulin with a flexpen with meals.The Treatment Administration Record (TAR) for January 2026 revealed the resident's lunch time blood sugar levels during the month ranged from 166 milligrams per deciliter (mg/dL) to 398 mg/dL.The Care Plan reviewed 11/21/25 included the diabetes diagnosis and directed staff to check the resident's blood sugar as needed for symptoms and administer insulin as ordered.A continuous medication observation on 1/13/26 at 11:20 AM revealed Staff A, Registered Nurse (RN) prepared an insulin flexpen to administer Resident #10's insulin. He removed the insulin pen from the medication cart, placed it and a sharps container on a portable bedside table and took it into the resident's room. He removed the insulin pen from the clear, plastic, sealable bag, removed the cap, placed a flexpen needle on the tip of the insulin pen, dialed the pen to 10 (units to administer) without priming the needle (to remove the air from the newly added needle and ensure the full dose of insulin is delivered), wiped the outer part of the resident's upper arm, placed the pen at a slightly elevated angle, and injected the contents into the resident's arm.At 11:25 AM, the state surveyor noted the insulin pen did not have an open date. Staff A stated insulin pens should be dated when they are opened and whoever opened it did not date it. He admitted he did not check the date before administering the insulin and should not have used it. He also stated he forgot to prime the needle but confirmed it was part of insulin administration.On 1/14/26 at 7:45 AM, Staff B, Certified Medication Aide (CMA) stated the nurses administer all insulins. She stated medication administration should involve staff verifying the 5-rights of medication administration (dose, drug, patient, route, & time) and label all newly opened medication with an open date.On 1/14/26 at 12:28 PM, the Director of Nursing (DON) stated staff should correctly assemble the insulin pen, prime the needle, and verify the dates on medications before administering them. She also confirmed this was not within professional standards.A policy titled Administering Medications revised April 2019 indicated when opening a multi-dose container, the date opened is recorded on the container.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Aspire of Perry		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 observations, staff interviews, and 2017 United States Food and Drug Administration (FDA) Food Code the facility failed to maintain a clean kitchen and food storage area that ensured the safety and protection of food prepared in one of one kitchen and food and supplies stored in one of one food storage area. The facility reported a census of 32 residents. Findings include: Observation of the facility's kitchen conducted on 1/11/26 at 2:05 p.m. revealed the following: a. A metal one cup scoop with a black plastic handle was found sitting in the flour of a bag of stone ground whole wheat flour. b. A metal one cup scoop with a metal handle was found with the metal handle sitting in the sugar of a bag of sugar. Observation of the kitchen's dry storage room on 01/11/26 2:09 p.m. revealed the following: a. Eight cardboard boxes sitting on the floor that included food items and single serve dinnerware items.b. A sticky fly strip that hung from ceiling with approximately half a dozen dead flies and numerous smaller mosquito-like insects. c. The floor was stained with a dried liquid residue and littered with remnants of cardboard, tape, and a section of metal cove base lying on the floor. Observation of the noon meal service on 1/13/26 revealed the following: a. At 12:27 p.m. the Dietary Manager assisted with the meal service by donning a pair of gloves and made two sandwiches on a prep table in the kitchen that were served to residents in the dining room. b. At 12:32 p.m., Staff I, Dietary [NAME] made a peanut butter sandwich on the prep table in the kitchen that was served to a resident in the dining room. c. At 12:35 p.m. the metal shelf above the prep table used to prepare the sandwiches was noted to be dirty with grime and debris which had sitting on it a plastic bag holder, hot pads, labels, a food cover, two dial weight scales, and three 12-ounce syrup containers. d. Around the same time, grime and debris were noted on top of the refrigerator that contained boxed juices for the residents and the window in the kitchen that had an air conditioner placed in it was noted to have a filter with accumulated fuzzy debris on it. In an interview on 1/13/26 at 12:59 p.m. with Staff I, Dietary Cook, and Staff J, Dietary Aide, they revealed:a. Staff I, Dietary Cook, stated he had worked at the facility for two months. b. Staff J, Dietary Aide, stated she had worked at the facility for seven months. c. When asked about a cleaning schedule for the kitchen, they both were unaware of any cleaning schedule and stated that after each meal service the dietary staff cleans up the kitchen. During an interview on 1/13/26 at 1:05 p.m. with the Dietary Manager, she stated she had been the Dietary Manager since May 2025 and when asked regarding a cleaning schedule for the kitchen and food service equipment, she stated she did not have a cleaning schedule for the staff to follow and stated we [dietary staff] pretty much clean as we go. Observation of the kitchen's dry storage room on 1/13/26 at 1:17 p.m. revealed the following:a. The eight cardboard boxes remained setting on the floor. b. The sticky fly strip that had hung from ceiling had been removed. c. The floor remained stained with a dried liquid residue and littered with remnants of cardboard and tape.e. The section of metal cove base that had been lying on the floor had been removed. During a phone interview on 1/13/26 at 2:50 p.m. with the Consultant Registered Dietitian, she revealed: a. She had been the Consultant Registered Dietitian since May 2025.b. She agreed with the concern for the general cleanliness of the kitchen and dry storage room. c. She stated she had discussed her concern with the general cleanliness of the kitchen with the facility. During an interview on 1/14/26 at 10:45 a.m. with the Dietary Manager, she revealed: a. She agreed the kitchen's dry storage room remained unclean with debris and stains.b. She stated a housekeeper would clean the floor when needed. On 1/14/26 at 10:50 a.m., Staff H, Housekeeper, revealed she: a. Could not remember the last time she had cleaned the floor of the kitchen's dry storage room. b. Stated the door was locked and she did not have a key. During an interview regarding (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the kitchen and dry storage room on 1/14/26 at 1:19 p.m., the Administrator revealed: a. She stated the sticky fly strip that hung from ceiling in the dry storage room with approximately half a dozen dead flies and numerous smaller mosquito-like insects should have been taken down by now.b. She had seen cleaning schedules in the kitchen over the past year and was surprised that the Dietary Manager did not have cleaning schedules in place. c. She expected daily, weekly, and monthly cleaning schedules for the kitchen. The 2017 Food & Drug Administration (FDA) Food Code included the following: a. Part 4-6 CLEANING OF EQUIPMENT AND UTENSILSb. Section 4-602.13 Nonfood-Contact Surfaces.Non FOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. c. Section 6-501.12 Cleaning, Frequency and Restrictions.Cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Aspire of Perry		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews, and policy review, the facility failed to implement infection control practices to prevent urinary tract infections (UTI) by failing to perform hand hygiene while emptying two (2) urine drainage bags for 1 of 1 resident (#6). The facility also failed to perform infection control process surveillance to ensure infection control process compliance. The facility reported a census of 32. Findings include:1) On 1/12/26 at 9:08 AM, Resident #6 stated he had a urinary catheter and a kidney drainage catheter and staff empty both. He also stated he had a urinary tract infection (UTI) in [DATE]. Observed an Enhanced Barrier Precautions sign posted at the resident's door. It directed:EVERYONE MUST:Clean their hands, including before entering and when leaving the room.PROVIDERS AND STAFF MUST ALSO:Wear gloves and a gown for the following High-Contact Resident Care Activities.DressingBathing/ShoweringTransferringChanging LinensProviding HygieneChanging briefs or assisting with toiletingDevice care or use: central line, urinary catheter, feeding tube, tracheostomyWound Care: any skin opening requiring a dressingThe Minimum Data Set (MDS) assessment for Resident #6 dated 10/29/25 revealed he had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of high blood pressure, kidney failure, blocked urine flow, and non-Alzheimer's dementia. It indicated he was independent with bed mobility, required setup assistance with eating and oral hygiene, required moderate assistance with personal hygiene, upper body dressing, and all forms of transfer mobility, and required maximal assistance with toileting hygiene, bathing, and lower body dressing. It also revealed the resident had a urinary catheter and a nephrostomy tube (tube surgically placed into the kidney to remove waste).The Electronic Health Record (EHR) included a physician's order dated 1/22/25 that directed staff to use Enhanced Barrier Precautions due to the resident's catheter use.A Progress Note dated 10/09/25 revealed the resident had an indwelling catheter with pus around the catheterThe Care Plan reviewed 11/25/25 indicated the resident required assistance with draining his catheter bag and nephrostomy tube.A continuous observation on 1/13/26 at 1:39 PM revealed Staff C, Certified Nurse Aide (CNA) drained Resident's #6's urinary catheter bag and nephrostomy bag. She put on an isolation gown, gloves, and an ear loop mask (Personal Protective Equipment - PPE) in the hall without performing hand hygiene. She entered the resident's room, moved the resident's bedside table, and helped him move his legs off his bed. She placed a drainage cylinder on the floor in a plastic bag, opened the urine catheter bag spigot, and emptied the contents into the cylinder. She cleaned the spigot end with an alcohol swab, tightened the spigot, and moved the cylinder to the resident's counter to empty it. She removed her gloves, put on new gloves, and placed the nephrostomy drainage cylinder on floor in a plastic bag. She opened the nephrostomy bag spigot, and emptied the contents into the cylinder. She wiped the spigot with an alcohol swab, tightened the spigot, took the cylinder to the counter, measured the volume, and emptied it into the toilet. She removed her gloves, tied the trash in knot, placed a new bag in the trashcan, and performed hand hygiene with soap and water.At 1:48 PM, Staff C stated she should have performed hand hygiene before putting on the PPE and between emptying each collection bag. She confirmed she received hand hygiene education upon hire which included performing hand hygiene at the beginning of a task, upon changing tasks, and after completion of a task. She also confirmed draining each bag was separate tasks.On 1/14/26 at 12:28 PM, the Director of Nursing (DON) stated staff should have performed hand hygiene between glove changes and follow the policy for catheter cares.A policy titled Handwashing/Hang Hygiene revised October 2023 indicated all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, (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	01/14/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents, and visitors. It revealed hand hygiene is indicated:immediately before touching a resident;before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device);after contact with blood, body fluids, or contaminated surfaces;after touching a resident;after touching the resident's environment;before moving from work on a soiled body site to a clean body site on the same resident; andimmediately after glove removal.2) On 1/14/26 at 9:22 AM, the Administrator stated she performed Infection Prevention surveillance audits but did not document them. She stated staff follows McGreer's criteria (standardized definitions for identifying infections like UTIs and respiratory infections in long-term care facilities (LTCFs) for surveillance) for suspected urinary tract infections and must call the on-call administrator to discuss if they have a concern about a possible infection in a resident. She stated the facility performs Infection Prevention competency check-offs for staff but confirmed there was no documented process surveillance that captured staff's infection prevention compliance to prevent cross-contamination or the spread of infection.On 1/14/26 at 12:48 PM, the Director of Operations stated the facility should have teachable moments to monitor an unannounced method that staff are compliant with the infection prevention policy of the facility.A policy titled Surveillance for Infections revised April 2025 indicated if transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the infection preventionist collects data to help determine the effectiveness of such measures.