

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Ascend at Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 South Hudson Avenue Aurora, MO 65605	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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: 265182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Ascend at Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 South Hudson Avenue Aurora, MO 65605	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents from misappropriation of property when staff could not account for two residents' (Resident #1 and #2) cards of controlled medications (narcotics) that had been in the possession of the facility. The facility census was 60. The Administrator and former Director of Nursing (DON) were notified on 11/23/25 of the missing medications. The facility completed an audit of resident medications, completed in-servicing of licensed staff who were involved in medication pass and medication storage, and notified families and physicians of the missing medications. The noncompliance was corrected 11/26/25. Review of the facility's policy Identifying Exploitation, Theft and Misappropriation of Resident Property, dated October 2025 showed the following:-As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property;-Exploitation, theft and misappropriation of resident property are strictly prohibited;-Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent;-Examples of misappropriation of resident property include drug diversion (taking the resident's medication);-Staff and providers are expected to report suspected exploitation, theft or misappropriation of resident property. Review of the facility's policy Controlled Substances, reviewed October 2025, showed the following:-The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances;-Only authorized nursing staff and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises;-The Director of Nursing Services (DNS) will identify staff members who are authorized to handle controlled substances;-Controlled substances must be counted upon delivery. The nurse receiving the medication, will count the controlled substances to ensure the right quantities are there. Authorized personnel will sign for delivery. Any discrepancies will be reported to pharmacy and Director of Nursing (DON);-Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services;-Reconciliation of controlled medications shall include number of cards and pills in each card;-The DNS shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify and responsibility parties, and shall give the Administrator a written report of such findings. Review of the facility's policy titled Discarding and Destroying Medications, reviewed October 2025, showed the following:-Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances;-All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of;-Schedule II, III and IV (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous controlled medications. 1. Review of the facility's investigation summary, dated 12/01/25, showed the following:-On Sunday, 11/23/25 at 12:42 A.M., the DON was notified by an agency Licensed Practical Nurse (LPN) that there was potentially missing/misplaced narcotics;-The DON alerted the Administrator on Sunday morning around 7:00 A.M. indicating that the facility had a potential medication error issue. The Administrator told the DON to meet her at the facility to investigate the allegation;-The DON and Administrator met at the facility around 9:00 A.M. This is when the DON mentioned to Administrator that the facility may be missing some controlled medications;-The DON told the Administrator that the regional team was notified and that she self-reported the potential allegation to the state;-The Administrator instructed the DON to investigate the allegation gather facts by auditing each chart, order, and medication cart, interview and gather staff statements and to report back to her if indeed medications were missing and where and who may be responsible for it;-On Tuesday morning, the regional team came in for a weekly visit and was made aware that there was an ongoing investigation into potentially missing narcotics;-The regional team brought in an external registered nurse (RN) to assist with the investigation as well;-Investigational findings showed all residents received their pain medications as ordered, every day, and every shift. The medication oxycodone/acetaminophen (APAP) (opioid pain medication) tablet 10-325 (30 tablet) cards that belonged to Resident #1 and Resident #2 that were reported missing, were not located. The narcotic count sheet matching the missing cards was provided by the DON and marked and co-signed as destroyed. 2</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Ascend at Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 South Hudson Avenue Aurora, MO 65605	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Ascend at Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 South Hudson Avenue Aurora, MO 65605	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews and record review, the facility failed to ensure all allegations of misappropriation of property were reported within 24 hours to the State Survey Agency (Department of Health and Senior Services-DHSS) when staff failed to report timely when they discovered two missing cards of narcotics for two residents (Resident #1 and Resident #2). The facility census was 60. The Administrator and former Director of Nursing (DON) were notified on 11/23/25 of the missing medications. It was discovered on 11/26/25 are report to DHSS had not been made. The facility completed in-servicing of staff and audits of records. The noncompliance was corrected on 11/26/25. Review of the facility's policy Identifying Exploitation, Theft and Misappropriation of Resident Property, dated October 2025 showed the following:-As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property;-Exploitation, theft, and misappropriation of resident property are strictly prohibited;-Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent;-Examples of misappropriation of resident property include drug diversion (taking the resident's medication);-Staff and providers are expected to report suspected exploitation, theft or misappropriation of resident property. 1. Review of the facility's investigation summary, dated 12/01/25 showed the following:-On Sunday, 11/23/25 at 12:42 A.M., the Director of Nursing (DON) was notified by an agency Licensed Practical Nurse (LPN) that there was potentially missing/misplaced narcotics;-The DON alerted the Administrator on Sunday morning around 7:00 A.M. indicating that the facility had a potential medication error issue;-The Administrator told the DON to meet her at the facility to investigate the allegation;-The DON and Administrator met at the facility around 9:00 A.M. This is when the DON mentioned to the Administrator that the facility may be missing some controlled medications;-The DON told the Administrator that the regional team was notified and that she self-reported the potential allegation to the state;-On Tuesday (11/25/25) morning, the regional team came in for a weekly visit and was made aware that there was an ongoing investigation into potentially missing narcotics. When the regional team discussed the allegation and investigation with the Administrator and DON, the Administrator realized that the DON did not report the allegation to the regional team;-The DON then admitted that she did not self-report this allegation to the state;-Investigational findings showed all residents received their pain medications as ordered, every day, and every shift. The medication oxycodone/APAP (opioid pain killer) tablet 10-325 (30 tablets) that belonged to Resident #1 and Resident #2 that were reported missing, were not located. Review of DHSS records showed the allegation of misappropriation was reported on 11/26/25. During an interview on 12/09/25, at 10:20 A.M., Registered Nurse (RN) B said the following:-Staff should notify the DON if a medication count is not correct;-Staff should report to DHSS in four hours if narcotics are missing or unaccounted for. During an interview on 12/09/25, at 10:29 A.M. and 11:15 A.M., Certified Medication Tech (CMT) C said staff should notify the DON if a medication narcotic count is not correct. Staff should report to DHSS of a misappropriation of property.During an interview on 12/09/25, at 1:06 P.M., CMT A said the following:-Staff should report to the DON if a narcotic count was not correct and not leave until investigated;-He/she considers a missing medication to be misappropriation of property;-Staff should report to the DON of any missing medications and to DHSS within two hours. During an interview on 12/09/25, at 10:57 A.M., RN D said the following:-Staff should notify the DON if a narcotic count is incorrect;-Staff should report to DHSS within two hours of misappropriation of property;-He/she considers misappropriation of property if a medication count is incorrect. During an interview on 12/09/25, at 1:40 P.M., the former DON said the following:-She and the Administrator decided it was not a two-hour reportable report due to it was not abuse;-She considered missing medications a misappropriation of property. During an interview on 12/9/25 at 11:30 A.M. the interim DON said the following:-She would consider missing medications misappropriation of property;-Staff should report to DHSS within two hours of misappropriation of property.During an interview on 12/09/25, at 1:26 P.M., the corporate Regional Director of Operations said the allegation of the missing narcotics should had been reported within 24 hours. During an interview on 12/09/25, at 11:30 A.M., the Administrator said the following:-She considered medications not found as misappropriation;-Staff should report to DHSS within 24 hours of a misappropriation of property;-She believed the former DON sent the allegation of misappropriation of property to DHSS on Sunday 11/23/25. Complaint 2679395</p>		